STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG. #69-1
CRANSTON, RHODE ISLAND 02920

In re: Market Conduct Examination of	)	
Blue Cross Blue Shield of Rhode Island:	)	**OHIC-2012-03**
Certain Rating and Underwriting Practices	)	

Final Order

This matter comes before the Health Insurance Commissioner (the "Commissioner") as a result of an examination of certain rating and underwriting practices of Blue Cross and Blue Shield of Rhode Island ("Blue Cross"). The examination was conducted on behalf of the Commissioner by Joseph Torti, III, Rhode Island Superintendent of Insurance, and by John Aloysius Cogan, Esq., (the "Examiners") pursuant to R.I. Gen. Laws §§ 27-13.1-1, *et seq.*, and pursuant to a warrant issued by the Commissioner on April 12, 2012. The Commissioner has considered and reviewed the Examiners' Final Report dated July 30, 2012 (the "Examination Report", or "ER") (attached hereto), and the response to the Examination Report submitted by Blue Cross on September 6, 2012. After full review and consideration of the Examination Report, the response of Blue Cross, and the Consent of Blue Cross set forth below, the Commissioner hereby issues the following Findings of Fact, Conclusions of Law, and Order:

Findings of Fact

1. The Commissioner hereby adopts the facts, conclusions and recommendations of the Examiners as set forth in the Examination Report, attached hereto and incorporated by reference herein, except as hereinafter expressly modified.

2. A targeted market conduct examination of Blue Cross & Blue Shield of Rhode Island ("Blue Cross") was ordered by the Commissioner of the Office of the Health Insurance

Commissioner ("OHIC") on April 12, 2010. The warrant for the examination appointed Joseph Torti, III and John Aloysius Cogan Jr. to represent the Commissioner in the examination, and stated that the examination was a targeted examination of certain rating and underwriting practices of Blue Cross to determine compliance with applicable statutes and regulations. ER at 3.

3. Blue Cross, a nonprofit hospital and medical service corporation, provides major medical health insurance, Medicare supplemental health insurance, and dental insurance to various non-group and group customers in Rhode Island. Blue Cross is the predominant health insurance in the major medical line of business, with over 70% market share. ER at 3-4.

4. OHIC convened a meeting with Blue Cross management and members of its Board of Directors on February 14, 2010 to discuss allegations of improper rating and underwriting practices by Blue Cross. As a result of that meeting and at the direction of OHIC, Blue Cross engaged Deloitte Consulting LLP (the "Auditor") to perform an independent assessment of Blue Cross's rating and underwriting processes. An examination warrant was issued thereafter, and the assessment commenced. At the conclusion of the assessment, the Auditor submitted its findings and recommendations to Blue Cross and OHIC in the form of two reports. These reports form the work papers for the examination and this Examination Report. ER at 5.

5. During the periods of time examined by the Auditor and the Examiners, Blue Cross engaged in the improper rating and underwriting practices set forth in Paragraph Nos. 6 through 11, below:

6. Blue Cross did not fully fund operating expenses attributable to large group business from large group rates during the last three quarters of 2009. This underfunding resulted from a conscious management decision to reduce rates for strictly competitive reasons. Consequently,

renewal rates charged to large groups during the last three quarters of 2009 were not actuarially sound and, from a financial standpoint, were not in the best interests of the Blue Cross. ER at 11. Blue Cross asserts in its formal response, attached hereto, that it has shared its operating expense allocation methodology, and policies and procedures for allocation with the Office and the Commissioner "to ensure that both offices [sic] agree with and understand that methodology." Such assertions by Blue Cross should not be construed to express or imply any approval by the Office and the Commissioner concerning Blue Cross' operating cost allocation methodology, or policies and procedures for allocation, and such assertions by Blue Cross do not express or imply any agreement between the Office or the Commissioner, and Blue Cross concerning the Blue Cross' operating cost allocation methodology, or policies and procedures for allocation.

7. Blue Cross did not file and receive approval from OHIC for its new business rate formula and rate manual for large groups. As a result, there was no regulatory oversight of the rates Blue Cross charged new large group customers during a portion of the period examined. ER at 12.

8. Blue Cross established a "Spend Down" account, in which all large group accounts were subject to a pooling charge. The account was intended to be used to strategically discount rates for large group renewal business for competitive, business reasons, rather than based on actuarially sound underwriting standards. The existence and purpose of the charge and account was not disclosed to OHIC during its annual rate factor review, nor was the charge and account filed and approved by OHIC as part of a rate formula or rate manual. ER at 13-14.

9. The documentation used by Blue Cross to develop large group medical and large group dental rate factors, and the documentation used to apply those rating factors in making

underwriting decisions for large group medical new and renewal business, large group dental new and renewal business, small group new and renewal business, and group Plan 65 (Medicare supplemental insurance) business was unclear and lacking in sufficient detail to permit post-underwriting review by internal compliance staff or regulatory examiners. ER at 15; ER at 18; ER at 21-22; ER at 42-44.

10. Blue Cross underwriters deviated from the carrier's filed and approved rating formula and rating manual, underfunded large group operating expenses, and made discretionary underwriting decisions, resulting in rate discounts offered to some group customers, but not to others, in connection with large group medical new and renewal business, large group dental new and renewal business, small group new and renewal business, and group Plan 65 (Medicare supplemental insurance) business. Such discounts were offered for competitive, business reasons, rather than based on actuarially sound underwriting standards. In many cases, discounts were offered to hit a "price point" and thereafter justified on the basis of "underwriting judgment". In other cases the Spend Down account was applied inconsistently as a rate discount mechanism. Large group rates were discounted by reducing operating expenses allocated to certain customer accounts. Blue Cross used revenue allocated for large group medical operating expenses to subsidize dental operating costs, thereby increasing the competitiveness of its dental rates. Groups purchasing multi-year guarantees were offered different rate caps in the second year, without documenting that the different cap levels were based on actuarially sound underwriting standards. Regardless of the particular discounting mechanism, such discounting resulted in arbitrarily lower rates for some groups, and arbitrarily higher rates for other groups. ER at 14-15; ER at 16-22; ER at 30-33.

11. Blue Cross renewal rates for its small group dental renewal business were not

developed and offered in compliance with the rating method it filed and obtained approval for by OHIC, resulting in arbitrarily lower rates for some small groups, and arbitrarily higher rates for other small groups. ER at 30-32.

12. Blue Cross' use of discounting mechanisms for business and competitive reasons, rather than based on actuarially sound underwriting standards, occurred in direct noncompliance with the express instructions given by OHIC and the Insurance Division of the Department of Business Regulation to Blue Cross in 2007 that such discounting was improper. Thereafter, Blue Cross' use of these improper discounting mechanisms was knowing, intentional, and in willful disregard of regulatory instructions and legal standards. ER at 16; ER at 31.

13. In its Direct Pay (non-group) business, Blue Cross used improper underwriting standards, and did not develop clear underwriting standards. ER at 33-38.

14. In its Plan 65 (Medicare supplemental insurance) business, Blue Cross failed to adequately document the reasons for rejecting an application, used incomplete and vague underwriting standards, and failed to file and obtain OHIC's approval of certain rate development methodologies. ER at 41-42. The Commissioner agrees with Blue Cross' assertion that it has established adequate underwriting guidelines for non-group Plan 65 applicants.

15. Any Conclusion of Law that is also a Finding of Fact is hereby adopted as a Finding of Fact.

Conclusions of Law

16. Paragraphs 1 through 15, above, are hereby incorporated into these Conclusions of Law.

17. The Commissioner has jurisdiction over this matter pursuant to Rhode Island General Laws §§ 42-14.5-1 et seq., 42-14-5(d), and 27-13.1 et seq.

18. The market conduct examination that culminated in the Examination Report was conducted in accordance with the provisions of Rhode Island General Laws §§ 27-13.1-1 et seq.

19. The failure of Blue Cross to fully fund large group operating expenses as described in Paragraph 7, above, and the establishment of a "Spend down" account as described in Paragraph 8, above, is in violation of Blue Cross' obligation to file the rate factors it intends to use, and to comply with the rate factors approved by the Commissioner. Rhode Island General Laws §§ 27-19-6(a) and (c), and 27-20-6(a) and (c); Department of Business Regulation Insurance Regulation No. 23, adopted by OHIC in OHIC Regulation No. 1.

20. By failing to file and obtain OHIC approval for its new business rate formula and rate manual for large groups, Blue Cross violated the legal requirement that its rate formulas and manuals not be used unless first approved by OHIC. Rhode Island General Laws §§ 27-19-6(a) and 27-20-6(a); Department of Business Regulation Insurance Regulation No. 23, adopted by OHIC in OHIC Regulation No. 1.

21. Blue Cross' inadequate documentation of its underwriting decisions is contrary to its legal obligation to properly conduct its business, and to act in the interest of the public. Rhode Island General Laws §§ 27-19-6(c) and 27-20-6(c).

22. By its use of rate discount mechanisms for competitive business reasons, rather than based on actuarially sound underwriting standards, as described in Paragraph Nos. 6 through 11, above, Blue Cross acted in an unfairly discriminatory manner, in violation of the Rhode Island Unfair Competition and Practices Act. Rhode Island General Laws § 27-29-4(7) makes clear that unfair discrimination in the development and use of insurance rates is an "unfair method of competition or an unfair and deceptive act or practice in the business of insurance." Rhode Island General Laws § 27-29-4(7)(iii), describes unlawful "unfair discrimination" as:

> "Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable under any policy or contract, or in any of the terms or conditions of that policy, or in any other manner."

Thus, the Rhode Island General Assembly has expressly forbidden discrimination by any health insurer between risks involving essentially the "same class" and of "essentially the same hazard" with respect to premiums, fees, rates charged, benefits, terms, conditions, or "in any other manner." In other words, if a health insurer differentiates between two customers in the same market ("members of the same class") and essentially the same hazard with respect to premiums, fees, or in any other manner for reasons other than sound actuarial principles or actual or reasonably anticipated experience, the insurer will have engaged in unlawful, unfairly discriminatory conduct with respect to its customers.

The inquiry with respect to unfairly discriminatory rates involves rates applicable to the "same class" and "essentially the same hazard." The inquiry must necessarily focus on whether differences in premiums, fees, or other charges applied to different groups within the same market reasonably reflect quantifiable differences in anticipated risk, loss experiences, or other generally acceptable methods of segregating risk. Such quantifiable differences must also be based on credible data. Rate differentials based on the desire to have a particular customer in an insurer's book of business, a competitor's rates, or any other non-actuarially sound basis are all unfairly discriminatory unless such rate differentials are expressly authorized by court order, statute, regulation, or other regulatory approval, or unless the differences are sufficiently small

that they are considered *de minimus*. To be clear, different premium rates would not be unfairly discriminatory for policyholders with like loss exposures if the premium differences were based on some other rational and objective criteria, such as different expense factors, as long as the final premium rates reflected such differences with reasonable accuracy; the use of such rational and quantifiable criteria, together with adequate documentation of such criteria to the particular customer or other specific circumstances constitutes the proper exercise of "underwriting judgment". In contrast, "underwriting judgment" as practiced by Blue Cross and found by the Examiners was both improper and not permitted by law..

23. Blue Cross' inadequate underwriting standards and documentation in its Direct Pay and Plan 65 business is contrary to its legal obligation to properly conduct its business, and to act in the interest of the public. Rhode Island General Laws §§ 27-19-6(c) and 27-20-6(c).

24. Blue Cross' failure to file and obtain OHIC's approval of certain rate development methodologies in its Plan 65 business violated the legal requirement that its rate formulas and manuals not be used unless first approved by OHIC. Rhode Island General Laws §§ 27-19-6(a) and 27-20-6(a); Department of Business Regulation Insurance Regulation No. 23, adopted by OHIC in OHIC Regulation No. 1.

25. The Examination Report makes 32 recommendations for corrective action, corresponding to the Examination Report's specific findings of improper and unlawful rating and underwriting practices engaged in by Blue Cross. As noted in Paragraph 14, above, the Commissioner concludes that the Examiners' finding upon which their Recommendation No. 28 was made was in error. Recommendation No. 5 of the Examination report suggests that a personal certification be made by Blue Cross' Chief Executive Officer and Chief Financial Officer in connection with any rate-related filing as to the truth and completeness of the filing.

The Commissioner concludes that Recommendation No. 5 is not necessary to accomplish the remedial objectives of this examination. The Commissioner observes that such a certification may be an appropriate regulatory tool, but if so should be used in connection with all carrier filings. The Examiners' Recommendation No. 32 suggests "to the extent that some Blue Cross customers were overcharged due to unfairly discriminatory rates, refunds should also be provided." The Commissioner declines to adopt this recommendation due to the practical difficulty of identifying with any degree of accuracy specific overcharge amounts. As to the remaining 29 Recommendations, Blue Cross has documented that it has taken corrective action to the satisfaction of the Commissioner with respect to Recommendation Nos. 7, 9, 13, 16, 19, 23, 24, 25, 27, 29, 30, and 31. The Commissioner concludes that a plan of correction and an order to implement the remaining Recommendation Nos. 1-4, 6, 8, 10-12, 14-15, 17-8, 20-22, and 26 is necessary and appropriate to cure the violations or laws, regulations and prior orders of the Commissioner as set forth in Paragraphs 1-24, above. Rhode Island General Laws § 27-13.1-5(c)(1).

26. The Commissioner may impose an administrative penalty on Blue Cross for violations, either with the consent of Blue Cross, or after notice and hearing. Rhode Island General Laws §§ 27-13.1-5(e)(3) and 42-14-16. Blue Cross has consented to the imposition of an administrative penalty, as demonstrated by its Consent, set forth below.

27. In considering an appropriate penalty amount, the Commissioner has taken into consideration the following mitigating and aggravating factors:

(a) As a mitigating factor, the Commissioner notes Blue Cross's full cooperation with the Examination, and the Examiners' description of the steps taken by Blue Cross, both as corrective actions and as actions independent of and prior to the Examination, to address some of

the improper practices identified in the Examination Report. The Commissioner also notes that Blue Cross' lead management officials are different from those in office during the examination period.

(b) Blue Cross' failure to file and obtain OHIC's approval for certain rating formulas and manuals, as well as its failure to comply with its approved formulas, is a very serious matter that goes to the heart of the ability of a regulator to protect the public and enforce health insurance laws and regulations. If rate formulas are not filed, OHIC has no opportunity to determine if those rate formulas are lawful and in the public interest, contrary to the expectations of the General Assembly and the public. If approved rate formulas are not complied with, such conduct also constitutes a very serious matter. State regulators can never expect to have the resources needed to conduct continuous audits of a regulated entity. Voluntary compliance with approved rates is essential to the proper functioning of the regulatory system, and to the protection of the public.

(c) Blue Cross' improper and unlawful rating and underwriting practices during the examination period are also a very serious matter. While it could be asserted that the discounting of rates offered to some Blue Cross customers have no effect on the rates of customers that are not offered discounted rates, the revenue available to an insurer to pay for its administrative costs, reserves and health care claims and other expenses is relatively fixed. Discounting rates for some customers is not only unfair to similarly situated other customers because those other customers do not receive the same lower rates, but those other customers also pay higher rates than are necessary but for the discounted rates to Blue Cross' favored customers. Depending upon the facts and circumstances, unfairly discriminatory rating and underwriting practices may also constitute unfair competition, in that other health insurance

carriers may run the risk losing customers to a carrier that may be competing in an unfair manner.

(d) The Commissioner acknowledges the following mitigating factors in connection with Blue Cross' discounting practices. OHIC heretofore has not established in a formal manner detailed standards to clarify what is meant by "unfair discrimination" in relation to a health insurer's rating and underwriting practices. Furthermore, the Commissioner is not aware that other states have established such standards.

(e) While it could be argued, therefore, that Blue Cross did not know that its practices violated Rhode Island law, such an argument is undermined by the Examiners' description of regulators' clear instructions to Blue Cross in 2007 that such practices were improper. The Commissioner concludes that Blue Cross' discounting practices were intentional violations of the law, and an administrative penalty should reflect the serious nature of an intentional violation.

28. In the formal response of Blue Cross dated September 6, 2012, attached hereto, Blue Cross has asserted in at least five instances that revisions to its rating and underwriting methodologies, policies and procedures should be held as confidential audit papers in accordance with R.I. Gen. Laws § 13.1-5(f). The Commissioner disagrees as a matter of law that the examination statute requires policies and procedures relating to rating and underwriting to be held confidential. Such policies and procedures are integral to the application of rates and rating formulas, which are subject to the prior approval of the Commissioner in accordance with R.I. Gen. Laws § 27-19-6, 27-20-6, and 42-62-13. There is a presumption that documents relating to proposed rates and rating formulas are to be open for public examination. R.I. Gen. Laws § § 27-19-6(a), 27-20-6(a), and 42-62-13(a). However, the Commissioner will entertain a request by

Blue Cross, supported by sufficient factual and legal analysis, that such policies and procedures should be kept confidential, after balancing the considerations of Rhode's Island's trade secret law with the public interest in access to the information on which the Commissioner's rate and rating decisions are made.

Order

Wherefore, it is hereby ORDERED:

A. The Commissioner hereby adopts the Examination Report and the Recommendations of the Examiners, except as expressly modified in Paragraphs 14 and 25, above.

B. On or before October 15, 2012, Blue Cross shall pre-file for approval by the Commissioner a proposed Plan of Correction. On or before October 30, 2012, Blue Cross shall file with the Commissioner a Plan of Correction, approved by the Commissioner, to implement the Examination Report's Recommendation Nos. 1-4, 6, 8, 10-12, 14-15, 17-8, 20-22, and 26.

C. The Plan of Correction shall include underwriting and documentation standards and procedures for the purpose of curing unfair discrimination in rating and underwriting, and a schedule for filing with OHIC all necessary revisions to Blue Cross' rate formulas and manuals applicable to each line of business. Before the Plan of Correction is pre-filed, the Commissioner intends to issue a Bulletin applicable to all health insurance and dental carriers establishing standards addressing unfair discrimination in group rating and underwriting.

D. Blue Cross shall implement and comply with the approved Plan of Correction, together with any supplemental orders necessary and appropriate to cure the violations with respect to these Recommendations.

E. Blue Cross shall pay a penalty in the amount of $250,000.00, payable by check made out to the General Treasury of the State of Rhode Island and delivered to OHIC within ten

business days of the date of this Order.

F. Within 30 days of the issuance of this Order, Blue Cross shall file with OHIC affidavits executed by each director of Blue Cross stating under oath that they have received a copy of the adopted report and related orders.

G. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate to cure the violations found in the Examination Report. Such further actions may include examinations designed to verify compliance with the requirements of this Final Order, and any supplemental orders. Blue Cross shall pay the costs of any such further actions or supplemental orders.

Dated at Cranston, Rhode Island this 28th day of September, 2012.

Christopher F. Koller
Health Insurance Commissioner

THIS ORDER CONSTITUTES A FINAL ADMINISTRATIVE DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS ORDER MAY BE APPEALED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT, CHAPTER 35 OF TITLE 42 WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.

Consent of Blue Cross and Blue Shield of Rhode Island

I. Blue Cross understands and agrees that this Order constitutes valid obligations of Blue Cross, legally enforceable by the Commissioner.

II. Blue Cross waives its right to judicial review with respect to the above-referenced

matter; provided, however, Blue Cross shall have a right to a hearing on any charge or allegation brought by OHIC that Blue Cross failed to comply with, or violated any of its obligations under this Order, and Blue Cross shall have the right to appeal any adverse determination resulting from such charge or allegation.

III. Blue Cross acknowledges and agrees that it consents to the legal obligations imposed by this Order, and that it does so knowingly, voluntarily and unconditionally.

IV. Notwithstanding the foregoing, this consent does not constitute an admission of any statement of fact or conclusions of law contained in the Examination Report or Order.

By: Chris Bunch Date: 9/24/2012

Title: VP underwriting

Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

VIA E-MAIL (Original will *not* follow)

September 6, 2012

Herbert W. Olson
Executive Counsel
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Bldg #69, 1st Floor
Cranston, RI 02920

RE: Targeted Market Conduct Examination of Certain Rating and Underwriting Practices of Blue Cross & Blue Shield of Rhode Island – Final Report dated July 30, 2012

Dear Mr. Olson:

Please accept this letter as Blue Cross & Blue Shield of Rhode Island's ("Blue Cross") written response to the above referenced Examination Report (the "Report") which was transmitted to Blue Cross on August 7, 2012. Having read the report and discussed it with our Executive Leadership team, on behalf of Blue Cross, I would like to assure the Commissioner that we take the findings and recommendations of the examiners very seriously.

It is important contextually to recap the timeframe during which the audit and examination were conducted. The audit was initiated by Blue Cross at the request of the Commissioner in March 2010 and the Warrant of Examination was issued on April 12, 2010. The period under examination was 2007-2009 – almost 3 years prior to the date of this response. During the course of the audit and examination, Blue Cross took a number of steps to address recommendations of the auditors and we have taken additional steps since then to further address recommendations of the auditors.

Because the findings in the Report expand upon the audit, Blue Cross has identified a number of findings that require additional remediation, mostly in the form of updated formula filings. As a result, a number of the responses below reflect that Blue Cross will file a Plan of Correction to address findings in the Report. We anticipate filing the Plan of Correction with the Commissioner by October 1, 2012; however, we understand that the Commissioner intends to issue guidance to all carriers regarding the Commissioner's expectations with regard to impartial and not unfairly discriminatory practices. In the event that the Commissioner's guidance is delayed, Blue Cross intends to delay filing its Plan of Correction such that Blue Cross will have at least two weeks in which to modify its Plan of Correction, if required, to take into consideration such guidance.

We note that a number of the findings appear to be the same or similar, albeit covering different markets. For ease in organizing our response, we have consolidated our response based on general topic of the findings. Nothing in this letter should be construed as an admission on the part of Blue Cross to any statement of fact or conclusion of law contained in the Report. With that in mind, Blue Cross responds to the Report as follows:

Attestation (Recommendation 5)
The assigned actuary on any given rate-related filing is responsible for preparing filings and certifying the accuracy of the filing. The Vice President of Underwriting and Chief Financial Officer provide oversight, input and approval of filings and all filings are reviewed by the Legal Department before submission. All rate filings are presented to the Executive Leadership Team (which includes the CEO, COO, CIO, Chief Administrative Officer/General Counsel, Chief Medical Officer, Chief Marketing Officer, Sr. Vice President of Network Management and Vice President of Human Resources) and to the Finance Committee of the Board of Directors prior to filing. Direct Pay rate filings are also presented to and approved by the full Board of Directors. We do not believe the proposed attestations present any increased protections to this existing review process; however, in the event the Commissioner adopts this recommendation, we recommend that the attestation be required of all carriers in all markets. We further recommend that the Commissioner adopt a "to the best of my knowledge" standard for such attestations, consistent with attestations required under the Sarbanes-Oxley Act.

Documentation and Consistency (Recommendations 7, 9, 13, 16, 24, 27, 31)
Blue Cross has submitted, under separate cover, a number of written policies and procedures that we have implemented to address standards for documentation in order to ensure consistency in our actuarial and underwriting areas. Blue Cross submitted these policies and procedures pursuant to RI Gen. Laws § 27-13.1-5(f), and they should be held as confidential audit papers.

RI Builders Association Rating (Recommendation 19)
This matter was previously identified and addressed in the course of a prior market conduct examination. Therefore, we believe it should be rejected by the Commissioner. See Market Conduct Examination of Blue Cross & Blue Shield of Rhode Island: Builders Association Business (OHIC 2011-06) dated August 17, 2011 (Recommendation 2(a)). To the extent this finding is accepted by the Commissioner, Blue Cross notes that it has sought and obtained OHIC approval of RI Builders Association Rates through the 2013 rate year and that RI Builders rates are currently being set consistent with small group rates.

Direct Pay Underwriting (Recommendation 23, 25)
Blue Cross has submitted, under separate cover, written policies and procedures which address these recommendations. Such policies and procedures were submitted as confidential audit papers and should be treated as confidential pursuant to RI Gen. Laws § 27-13.1-5(f).

Rate Factor Filings/Compliance (Recommendations 3, 4, 20)
Blue Cross notes that it filed its Large Group Formula on February 5, 2010 and obtained Commissioner approval on April 19, 2010. In addition, group rating factors have been filed and approved annually in accordance with the Commissioner's guidance since the process was initiated in 2008. In addition, we will disclose and explain any and all rating factors that produce more than a de minimus effect, as and to the extent directed by the Commissioner, as part of our next formula filing. Blue Cross will submit a Plan of Correction which will include a timeline of anticipated filing dates for its revised formulas and associated rating factors.

Formula Compliance (Recommendations 2, 11, 29)

Blue Cross notes that it filed its Large Group Formula on February 5, 2010 and obtained Commissioner approval on April 19, 2010. The Plan of Correction will include a timeline of anticipated filing dates for revisions to our current approved formulas based upon the Report. In order to ensure that all carriers are operating under consistent requirements, we recommend that the Commissioner issue written guidance regarding his expectations for formula and rate factor filings and compliance therewith to all carriers.

Impartial and Not Unfairly Discriminatory Practices (Recommendations 10, 14, 17, 21, 22, 26, 30)
It is our understanding that the Commissioner intends to issue written guidance on this topic to all health and dental carriers in the near future. Blue Cross disagrees with the conclusion of the examiners that rates were developed in a manner that were not impartial, or were unfairly discriminatory. Nevertheless, Blue Cross's Plan of Correction will reflect the actions we will take consistent with that guidance.

Operating Expenses (Recommendations 1, 6)
Blue Cross disagrees with the conclusion of the examiners that operating expenses have not been fully recognized in our premium rate development and/or were not actuarially justified, and the conclusion that operating expenses were used to attract a larger base of dental insurance consumers through anti-competitive pricing. Nonetheless, we will submit, as part of the Plan of Correction, a timeline of anticipated filing dates for revisions to our current approved formulas based upon the Report.

We note that Blue Cross has taken steps to share its allocation methodology, policies and procedures for allocation in rating with the Office of Health Insurance Commissioner and the Department of Business Regulation to ensure that both offices agree with and understand that methodology. Such methodology, policies and procedures were submitted as confidential audit papers pursuant to RI Gen. Laws § 27-13.1-5(f).

Single Consolidated Adjustment (Recommendations 1, 8, 12, 15)
Blue Cross notes that it filed its Large Group Formula on February 5, 2010 and obtained Commissioner approval on April 19, 2010. We understand that modifications may be necessary to address findings in the Report and will submit, as part of the Plan of Correction, a timeline of anticipated filing dates for revisions to our current approved formulas based upon the Report.

Non-Group Plan 65 Underwriting Guidelines (Recommendations 28)
Blue Cross has submitted documentation under separate cover to reflect that our non-group Plan 65 guidelines are up to date. Such guidelines were submitted as confidential audit papers and should be held as confidential pursuant to RI Gen. Laws § 27-13.1-5(f). We believe this Recommendation should be rejected by the Commissioner as we have demonstrated that the recommendation is based upon erroneous information.

Underwriting Guidelines (Recommendation 18)
Blue Cross has submitted, under separate cover, a number of written policies and procedures for dental underwriting. Such policies and procedures were submitted as confidential audit papers and should be held as confidential pursuant to RI Gen. Laws § 27-13.1-5(f). The Plan of Correction will address any outstanding issues.

Restitution (Recommendation 32)
We note that the report generally identifies that the findings resulted in losses to Blue Cross and there is no allegation that any one customer paid more because another paid less. We urge the Commissioner to reject this finding as the Report does not reflect sufficient information upon which Blue Cross could calculate any such restitution.

In addition to the specific responses noted above, Blue Cross has adopted an audit plan which includes audits of our rating and underwriting practices to be conducted by our internal audit department as well as external auditors engaged by our internal audit department. We have submitted a copy of the audit plan under separate cover. Such audit plan has been submitted as confidential audit papers pursuant to RI Gen. Laws § 27-13.1-5(f).

In reviewing the audit reports and Examination Report, we note that there are a number of areas in which it is noted that Blue Cross's practices are generally consistent with industry standards. While we fully intend to comply with the expectations and guidance of the Commissioner, and without downplaying the seriousness of the findings and recommendations of the report, we believe that our practices during the examination period were generally consistent with the rating practices of other carriers in Rhode Island and nationally. We further note that, especially with regard to the sections of the Report relating to "unfair discrimination", the Commissioner has not specified his expectations in written guidance to the carriers in Rhode Island, and Blue Cross is being held accountable by the examiners for those areas prior to the dissemination of expectations by the Commissioner, and without knowledge of whether other carriers are being held to the same standards.

We hope that this letter, along with the commitment to file a Plan of Correction in a number of areas, fully addresses the recommendations. If you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,

Monica A. Neronha
Vice President, Legal Services

cc: Peter Andruszkiewicz
Chris Bush

Blue Cross & Blue Shield of Rhode Island

Targeted Market Conduct Examination of
Certain Rating and Underwriting Practices of Blue Cross & Blue Shield of Rhode Island
To Determine Compliance With Applicable Statutes and Regulations

Final Report July 30, 2012

Office of the Health Insurance Commissioner

Blue Cross & Blue Shield of Rhode Island
Market Conduct Examination

TABLE OF CONTENTS

July 30, 2012

Honorable Christopher Koller
Health Insurance Commissioner
State of Rhode Island

Dear Commissioner Koller:

In accordance with your instructions and pursuant to statutes of the State of Rhode Island, a targeted Market Conduct Examination with regard to certain underwriting and rating practices was conducted in order to ascertain compliance with applicable statutes and regulations; evaluate the use and application of rating and underwriting processes, procedures and requirements; and assess whether current rating and underwriting practices pose a financial risk to the solvency of:

Blue Cross & Blue Shield of Rhode Island

The examination was conducted by Joseph Torti, III, Deputy Director and Superintendent of Insurance, Rhode Island Department of Business Regulation, Cranston, RI and John Aloysius Cogan Jr. of State College, PA (the "examiners"). The examination was conducted in accordance with the standards contained in the NAIC Market Analysis Handbook.

Joseph Torti, III
Deputy Director and Superintendent of Insurance
Rhode Island Department of Business Regulation

John Aloysius Cogan Jr.

1. Warrant Ordering a Targeted Market Conduct Examination

A targeted market conduct examination of Blue Cross & Blue Shield of Rhode Island ("Blue Cross") was ordered by Commissioner Christopher F. Koller of the Office of the Health Insurance Commissioner ("OHIC") on April 12, 2010. The warrant for the examination appointed Joseph Torti, III and John Aloysius Cogan Jr. to represent the Commissioner in the examination, and stated that the examination was a targeted examination of certain rating and underwriting practices of Blue Cross to determine compliance with applicable statutes and regulations.

2. Background and Reason for Examination

Blue Cross, a nonprofit hospital and medical service corporation, is the predominant health insurer in Rhode Island.[1] Blue Cross provides health insurance to various non-group and group customers in the Rhode Island market. Comprehensive non-group health insurance is provided to individuals and families though Blue Cross's Direct Pay line of products. Blue Cross also provides non-group Medicare Supplemental Insurance to individuals through its Plan 65 line of products. Group coverage is provided to large employer groups with 51 or more employees, small employer groups with 1-50 employees, and also to groups purchasing Plan 65 products. In addition, Blue Cross provides group coverage to the Rhode Island Builders Association ("RIBA"), whose membership is limited to those who are actively involved in supporting the construction industry in Rhode Island. Blue Cross also provides dental coverage to both group and non-group customers.[2]

Blue Cross's medical and dental products are subject to a variety of statutory and regulatory requirements and different levels of regulatory oversight by OHIC. For example, Blue Cross's

[1] While technically not a health insurer, see R.I. Gen. Laws §§ 27-19-2 and 27-20-2, Blue Cross is nevertheless subject to most of the laws governing health insurers and is treated, for most purposes, in a manner similar to other providers of health coverage in the state. Blue Cross is therefore referred to throughout this report as a health insurer.

[2] Blue Cross also provides administrative services to a range self-insured customers, including corporations and municipalities. These administrative services were not subject to this examination.

Direct Pay line of products is subject to an annual rate hearing and ongoing oversight by OHIC. Likewise, Blue Cross's small employer group business is subject to the R.I. Gen. Laws §§ 27-50-1, *et seq.*, the Small Employer Health Insurance Availability Act (the "Act"), and OHIC Regulation 11. While Blue Cross's Direct Pay and small employer group lines are subject to the highest level of regulatory oversight and scrutiny, its large group and dental lines are subject to the least amount of regulatory oversight. While no regulations have been promulgated specifically for Blue Cross's Direct Pay, large employer group, or dental lines of business, products and rates in those markets are subject to various other requirements, including Department of Business Regulation ("DBR") Insurance Regulation 23, incorporated by OHIC Regulation 1. Rate manuals for all lines of business other than Direct Pay and small employer group must be filed with and approved by OHIC pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6 and DBR Regulation 23 and OHIC Regulation 1. In addition, rate and trend factors for Blue Cross's small and large employer group lines of business must be filed with and approved by OHIC annually.

Over the last several years, various problems have been noted by OHIC with respect to Blue Cross's rating and underwriting practices. These problems included:

- Use of the health status rating adjustments to manipulate rates in the small employer group market, which resulted in a market conduct examination and a settlement involving approximately $2 million in restitution and penalties;
- The issuance of a show cause order related to the aforementioned small employer group rating adjustment after Blue Cross failed to cease using inappropriate rating practices after a written demand from OHIC to cease such practices;
- A violation of the settlement agreement reached as a result of the aforementioned show cause order;
- A failure to use an approved rating manual for Blue Cross's new business accounts in the large employer group market;
- Use of rating procedures that directly contradicted express guidance given to Blue Cross by OHIC in 2007 as a part of the approval process for Blue Cross's large employer group renewal business manual;

- Classification of certain large employer group accounts as "new business" so as to avoid application of constraints contained in Blue Cross's approved large group renewal business manual;
- Inappropriate rating practices in the dental market that included the use of unauthorized rate discounts and surcharges for certain accounts that appear to have been imposed based solely in response to quotes provided to those accounts by a Blue Cross competitor;
- Re-pricing of RIBA rates in response to pressure from the group; and
- Use of inconsistent underwriting criteria and discounts for large groups.

In general, these practices were not authorized by law, not provided for in rate manuals, and in some cases were expressly prohibited by OHIC prior to Blue Cross's use of the particular practice. These systematic, intentional, and aggressive efforts by Blue Cross to market its products led to concerns by OHIC personnel that Blue Cross was applying its underwriting and rating rules inconsistently and in a manner designed only to retain it customer base. OHIC was concerned that Blue Cross's rating and underwriting practices presented a serious financial risk to the organization and potentially placed Blue Cross's solvency in jeopardy.

OHIC convened a meeting with Blue Cross management and members of its Board of Directors on February 14, 2010 to discuss OHIC's concerns. As a result of that meeting and at the direction of OHIC, Blue Cross engaged Deloitte Consulting LLP (the "Auditor") to perform an independent assessment of Blue Cross's rating and underwriting processes. An examination warrant was issued thereafter, and the assessment commenced. At the conclusion of the assessment, the Auditor submitted its findings and recommendations to Blue Cross and OHIC in the form of two reports. These reports form the work papers for the examination and this examination report.

3. Overview, Scope, and Objectives of the Examination

The Auditor was charged with determining if Blue Cross's rate setting and underwriting practices, policies, and procedures were in compliance with regulatory requirements including, but not limited to, statutes, OHIC rating standards, and approved filings. Additionally, the

Auditor determined if Blue Cross's practices were actuarially sound, reasonable, and consistent with industry standards and leading practices. The scope of review included both medical and dental products in Blue Cross's commercial (insured) markets. The Auditor evaluated the actuarial rate setting process, new business underwriting, and renewal underwriting for small employer, RIBA, and large employer group medical and dental products with effective dates between 2007 and 2009. The Auditor also evaluated the underwriting process for the Direct Pay, non-group Plan 65, and experience-rated group Plan 65 products, including actuarial rating related to the group Plan 65 products (including major medical, prescription drug, and vision riders). In addition, the Auditor evaluated the processing of AccessBlue applications related to Direct Pay products.

Each of Blue Cross's commercial product lines was reviewed with respect to rate setting practices including whether rating factors were applied consistently, in an impartial manner, and in accordance with documented policies and procedures, approved rate filings, rate manuals (where applicable or available), Rhode Island statutes, and Rhode Island regulations (both OHIC and DBR). In addition, the Auditor assessed whether rate setting practices were actuarially sound and reasonable and financial controls inherent in the rate setting process were adequate.

The Auditor also evaluated Blue Cross's Statistical, Actuarial, and Underwriting ("SAU") department practices, including the technology and tools used, the structure of the department, and the qualifications of the staff. Finally, the assessment was completed by discussing the rating process with members of the SAU department, reviewing rate filings, reviewing development of rating factors, replicating rate calculations for accuracy, reviewing underwriting files, and reviewing the development of tasks.

One of the express goals of the assessment was to ascertain whether Blue Cross followed applicable Rhode Island statutes and regulations, whether rates were calculated according to filed formulae, and whether rates were computed in an impartial manner. The Auditor considered rates to have been computed in an impartial manner if rate calculations were documented, based on a formula, and applied consistently. If rates were not documented, not based on a formula, or

not applied consistently, the rates were not considered to have been computed in an impartial manner.

The concept of impartial rates, which was developed and applied solely for the purposes of the Auditor's assessment, is somewhat different from, but nevertheless inextricably intertwined with, the statutory concept of unfair discrimination in the development and use of insurance rates. Rhode Island General Laws § 27-29-4(7) makes clear that unfair discrimination in the development and use of insurance rates is an "unfair method[] of competition and [an] unfair and deceptive act[] or practice[] in the business of insurance." Rhode Island General Laws § 27-29-4(7)(iii), describes "unfair discrimination" as:

> Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable under any policy or contract, or in any of the terms or conditions of that policy, or in any other manner.

Thus, the Rhode Island General Assembly has expressly forbidden discrimination by any insurer,[3] including Blue Cross,[4] between risks involving essentially the "same class" and of "essentially the same hazard" with respect to premiums, fees, rates charged, benefits, terms, conditions, or "in any other manner." In other words, if an insurer differentiates between two members of the same class and essentially the same hazard with respect to premiums, fees, or in any other manner for reasons other than sound actuarial principles or actual or reasonably

[3] R.I. Gen. Laws § 27-29-3 ("No person shall engage in this state in any trade practice which is defined in this chapter as, or determined pursuant to this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.")

[4] Chapter 29 of title 27 expressly applies to Blue Cross. R.I. Gen. Laws § 27-29-2(4) ("'Insurer' means any . . . legal entity engaged in the business of insurance . . . . Notwithstanding any other provision of law, insurer shall also mean a nonprofit hospital and/or medical service corporation . . . as defined in the general laws, or any other entity providing a plan of health benefits. For the purposes of this act, the entities in this subdivision shall be deemed to be engaged in the business of insurance and subject to this chapter . . . .").

anticipated experience, the insurer will have unfairly discriminated[5] and will be in violation of Rhode Island law.[6]

It should be noted, however, that any inquiry with respect to unfairly discriminatory rates involves rates applicable to the "same class" and "essentially the same hazard." These terms, however, are not so broad as to afford an insurer the ability to distinguish between an infinite number of barely perceptible differences between individuals or groups in order to impose different premiums, fees, or other charges on such individuals or groups. Such an approach would render the statute's prohibition meaningless. Instead, the inquiry must necessarily focus on whether differences in premiums, fees, or other charges applied to different groups within the same market reasonably reflect quantifiable differences in anticipated risk, loss experiences, or other generally acceptable methods of segregating risk. Such quantifiable differences must also be based on credible data. Rate differentials based on whim, the desire to have a particular customer in an insurer's book of business, a competitor's rates, or any other non-actuarially sound basis are all potentially unfairly discriminatory unless such rate differentials are expressly authorized by court order, statute, regulation, or other regulatory approval, or unless the differences are sufficiently small that they are considered *de minimus*.

The terms "not impartial" and "unfair discrimination" overlap because rates that are not impartial, that is, rates that are not documented, not based on a formula, or not applied consistently, will of necessity be unfairly discriminatory if those rates were not impartial as between two similarly situated policyholders within the same market. Thus, while both "not impartial" and "unfair discrimination" will be used throughout this report, the relevant term used

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[5] Despite its use of the term "discrimination," nothing in this definition suggests that unfair discrimination requires proof that the difference in treatment was based on a specific legal classification such as race, alienage, age, gender, or disability, and is therefore not limited to what are generally understood to be protected classes. Instead, statute is designed to ensure that equal terms are fixed for similarly situated policyholders. In other words, the statute prohibits practices such as preferential rates, hidden rebates, excess charges, and other non-standard actions with respect to the cost of coverage or the benefits provided so that all similarly situated policyholders are treated alike.

[6] To be clear, different premium rates would not be unfairly discriminatory for policyholders with like loss exposures if the premium differences were based on some other rational and quantifiable criteria, such as different expense factors, as long as the final premium rates reflected such differences with reasonable accuracy.

in this report for the purposes of assessing Blue Cross's compliance with its statutory obligations is the statutory term "unfair discrimination."

4. Summary of Findings

While specific findings and specific recommendations are detailed throughout the report (and a complete list of recommendations are set out in Appendix A), the findings with respect to Blue Cross's rating and underwriting practices in general can be briefly summarized as follows:

- Rates were sometimes not developed or applied in an impartial and consistent manner and, in some cases, were unfairly discriminatory;
- Underwriters enjoyed overly broad discretion;
- Rates were not always correctly or appropriately documented;
- Certain required rate-related filings were not made;
- Certain rating components utilized in the rate making process were not fully disclosed in required filings;
- Certain rates were developed without adherence to approved rate filings;
- Some rate decisions were inappropriately based on competitive concerns; and
- The administrative components of certain rates of one product line were cross-subsidized with premium from another product line.

In short, the report reveals rating and underwriting practices that are non-compliant with statutory and regulatory requirements and potentially risky from a financial solvency standpoint.

5. Organization of the Report

This report is organized by market and then by the various processes employed by Blue Cross within each such market. The report begins with Blue Cross's Large Group Market business. The Large Group rating, renewal underwriting and new business underwriting processes are discussed separately.[7] Recommendations are made throughout the Large Group rating section of

[7] Underwriting is the process by which an insurer appraises and evaluates the risk of specific individuals or groups and uses those risk characteristics to apply a rate formula. The actuarial rating process develops

the report based on specific findings of the examiners. The same basic format is followed for Blue Cross's business in its Large Group Dental, Small Group and the Rhode Island Builders Association, Small Group Dental, Direct Pay, Non-Group Plan 65, and Group Plan 65 markets. Understanding this framework will assist the reader's comprehension and alleviate what might otherwise be perceived as a repetitive quality.

6. Large Group Actuarial Rating

The Auditor reviewed large employer group rating models and documentation supporting the large employer group medical actuarial rating process, including the derivation of community premium rates[8] and other rating factors for 2007 to 2009, the period covered by the audit. During the relevant period, large group rates were developed by analyzing the community claim costs for fully insured, non-fully credible groups, over a twelve month incurred period. This community rate was projected to the applicable time period and normalized for age/gender, benefit level, and credibility.

Factors, including liability factors,[9] new benefit adjustment factors,[10] projection (or trend) factors,[11] operating expenses,[12] pooling charges,[13] and completion factors were applied to the community rate to determine the rate for each group. The rating formula developed by the

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a rating formula that the insurer uses to determine rates that will cover the potential claims, administrative costs, and expected profit for groups within a market. The purpose of underwriting is to sort insured (or potentially insured) individuals or groups on the basis of similar risks and accept, deny, limit coverage, or impose rate differentials based on such individuals or groups.

[8] This term should not be confused with statutorily-based Small Group community rating provided for in R.I. Gen. Laws § 27-50-5.

[9] These account for out-of-system payments (e.g., electronic medical record physician incentive payments).

[10] These were applied to account for the impact of expected changes to health care consumption patterns.

[11] There were three main components to trend: utilization trend (determining the best-fit trend using a regression model based on prior experience) and price and mix trends. Price and mix trends were based on an analysis of factors provided by the contracting department, PBMs, and actuarial reflecting the anticipated changes in cost per service over time.

[12] Operating expenses were projected based on the budget provided by the finance department.

[13] The pooling charge was calculated based on prior experience at various attachment points. As discussed more fully below, the pooling charge used for renewal business included a load, referred to as the "spend down," which was used to fund a portion of the market concessions/underwriting manual adjustments Blue Cross applied to the rating of various groups.

actuarial department and utilized by the underwriters to calculate a group's rate was then adjusted based on the group-specific characteristics such as age/gender, benefit level, credibility, broker commissions, participation level, and underwriter judgment factors. General, non group-specific factors, such as retention charges (administrative costs such as claims handling expenses, general overhead, etc.) and taxes were also applied.

In general, the Auditor found that large employer group rates appear to have been calculated using leading actuarial practices, with one exception. Blue Cross did not fully fund operating expenses during the last three quarters of 2009. This occurred even though OHIC approved rate increases that were lower than those requested by Blue Cross. This underfunding appeared to result from a conscious management decision to reduce rates for strictly competitive reasons. The Auditor estimated that the underfunding resulted in a loss of approximately 1% of premium for groups renewed during the last three quarters of 2009. Consequently, renewal rates charged to large groups during the last three quarters of 2009 were not actuarially sound and, from a financial standpoint, were not in the best interests of the Blue Cross.

Recommendation 1: *Operating expenses should be fully funded. If competitive adjustments are to be made, such adjustments should be made as part of a single, consolidated adjustment, subject to the limitations discussed below.*[14]

With respect to the proper application of statutes and regulations to large group rate development, the Auditor determined that rate development during the relevant period was not completely consistent with R.I. Gen Laws §§ 27-19-6 and 27-20-6 and DBR Insurance Regulation 23, incorporated by OHIC Regulation 1. The large employer group market is not as heavily regulated as other markets, such as the small employer group market. Thus, the most significant requirements related to the large employer group market are: (1) that the rating formula to be used by a carrier must be filed and approved prior to use[15] and (2) that rating

[14] This recommendation applies to all Blue Cross business, not just Large Group business.
[15] R.I. Gen Laws §§ 27-19-6(a) and 27-20-6(a) (requiring Blue Cross to file its proposed rates or proposed rating formula for approval with OHIC prior to use); DBR Reg. 23, Part XI, Section 1, incorporated by OHIC Reg. 1 ("No health benefit contract shall be issued or delivered to any person in this state . . . until . . . the premium rates or the rating formula have been approved" by OHIC.).

factors to be used by a carrier must be filed annually and approved prior to use.[16] Blue Cross failed to fully adhere to both of these requirements during the period covered by the audit.

Prior to the initiation of the audit, OHIC determined that, although Blue Cross filed and received approval for its renewal rate formula, it never filed its new business rate formula for approval as required by R.I. Gen Laws §§ 27-19-6(a) and 27-20-6(a) and DBR Insurance Regulation 23, Part XI, Section 1, incorporated by OHIC Regulation 1. Since renewal rates were developed based on the filed and approved renewal formula, this aspect of large group rate development was consistent with applicable laws. However, the development of new business large group rates was not based on a filed and approved rate formula and was therefore not consistent with Rhode Island laws and regulations during the period covered by the audit and for a considerable period of time prior to the period covered by the audit. Essentially this means that there was no regulatory oversight over the rates charged by Blue Cross, the dominant carrier in the market, to its large group new business customers during that period. The examiners cannot overstate the seriousness of this problem. In response to OHIC's instructions, Blue Cross filed a rate formula and manual on February 5, 2010 that covers both new and renewal business.

Recommendation 2: *Blue Cross must ensure that it develops its new and renewal rates based on a filed and approved rate formula.*

Recommendation 3: *Blue Cross must ensure that it complies with all filing and approval requirements before it offers rates.*

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[16] Annual trend factor filings for Large Group were required on an annual basis beginning in 2008. Prior to 2008 Large Group trend filings were made periodically by health insurers with no time limit on agency approval. This changed in 2008 when health insurers in the Large Group market were informed that approval would last for only one year. See, e.g., February 28, 2008 letter from Christopher F. Koller to John Lynch and Carolann Smith regarding Large and Small Group annual filings. The letter states that Large Group trend factors to be used in each company's rating formula will be effective for a one-year period (available at http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/4_Large%20and%20Small%20Group%20filing%20letter%202-28-08.pdf). See also May 28, 2008 Approval Letter from Christopher F. Koller to John Lynch approving Blue Cross's Large Group trend filing for a period of one year (available at http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/8_BCBSRI%20lg%20group%20approval.pdf).

The Auditor also identified a "Spend Down" account, which was used by Blue Cross to strategically adjust rates for renewal business. The Spend Down account was funded by a pooling charge. The impact of the pooling charge on rates over the review period was -0.02% to 0.42%. Yet, these charges were neither included in any of the annual large group rate factor filings made by Blue Cross nor were they described or defined in any formula filings submitted to OHIC, in violation of R.I. Gen Laws §§ 27-19-6(a) and 27-20-6(a); DBR Insurance Regulation 23, Part XI, Section 1, incorporated by OHIC Regulation 1; and various annual trend filing approvals issued by OHIC.[17] This is another lapse on the part of Blue Cross for which the examiners cannot overstate the seriousness of their concern. When brought to light, such undisclosed charges not only tend to undermine public confidence in the regulatory process, they also tend to breed public distrust and suspicion of Blue Cross.

Prior to the 3rd quarter of 2009, the Spend Down account was not equivalent to the pooling charge loaded into the rates. Blue Cross intended to apply an excess load, above its expected need for the Spend Down account, to increase the reserve contribution. This was not disclosed to OHIC during the rate factor filing process. Since Blue was required to specify its projected reserve contribution in its annual rate factor filing submitted to OHIC, the Auditor found that Blue Cross was not completely forthcoming in its large group rate factor filing. The Auditor did, however, conclude that the full margin load was spent. Thus, Blue Cross ultimately did not contribute more to reserves than outlined in its rate filing. However, the fact that Blue Cross fully spent the margin load does not excuse its failure to fully disclose the load to OHIC during its rate factor filing.[18] The failure to disclose the excess load, the Spend Down account, and the rate adjustments there from constitute violations of R.I. Gen Laws §§ 27-19-6(a) and 27-20-6(a);

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[17] See, e.g., May 28, 2008 Approval Letter from Christopher F. Koller to John Lynch (available at http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/8_BCBSRI%20lg%20group%20approval.pdf).

[18] In its February 5, 2010 rate manual filing, the Auditor noted that Blue Cross mentioned that the pooling charge may replace large claims removed from experience, but the Auditor also noted that the filing does not indicate that the pooling charge will include a load to fund the Spend Down account. The Auditor concluded that the pooling charge was not being utilized for its intended purpose based on the rate filing submitted to OHIC.

DBR Insurance Regulation 23, Part XI, Section 1, incorporated by OHIC Regulation 1; and various annual trend filing approvals issued by OHIC.[19]

Although BCBSRI files projection factors with OHIC, additional factors that could impact rate changes were not filed. These factors included contracting adjustments, new benefit factors (state mandated benefits, prescription drug patent expiration, etc.), and pooling charges. The Auditor concluded that these factors had a negligible impact on the rate increase estimates filed with OHIC and did reflect the most up-to-date information available. Blue Cross's rate filings did indicate that these factors exist and that they were not filed with OHIC. Further, Blue Cross did caveat in their rate filing that projected rate increases could change due to updated experience, cancellations, and other such factors.

Recommendation 4: *Blue Cross must fully disclose and explain in its filed and approved formula and its annual rate factor filing all large group rating components, charges, and loads that are intended or expected to produce more that a de minimus effect on large group rates. For those rating components, charges, and loads that are intended or expected to produce a de minimus effect on large group rates, Blue Cross must provide more than a summary explanation.*

Recommendation 5: *The Chief Executive Officer and Chief Financial Officer of Blue Cross must personally certify in any required rate-related filing that Blue Cross has fully disclosed all rating components, charges, loads, and factors that are intended or expected to produce more than a de minimus effect on rates. The CEO and CFO must also certify that the filing (1) is true and complete, (2) contains neither untrue statements of material fact nor omissions of material fact, and (3) is not misleading.*[20]

The Auditor also found that medical operating expenses were used to partially fund dental operating expense costs in order to develop more competitive dental rates. Blue Cross did this by loading medical expense costs for a portion of the expense costs that were required to administer

[19] See, e.g., May 28, 2008 Approval Letter from Christopher F. Koller to John Lynch (available at http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/8_BCBSRI%20lg%20group%20approval.pdf).

[20] This recommendation applies to all Blue Cross business, not just Large Group business.

its dental products. This resulted in a lower than required dental rate, which made dental premiums appear more competitive. Blue Cross's goal was to attract a larger base of dental insurance consumers through anti-competitive pricing.

Recommendation 6: *Blue Cross should not cross-subsidize its dental business operating expenses with its medical business operating expenses unless such cross-subsidization is actuarially justified and fully disclosed to OHIC.*

The Auditor also noted that documentation related to the development of the large group rating factors was neither robust nor easy to follow. This presents a potential regulatory oversight problem should OHIC determine further inquiry into large group rate development is necessary. It also poses potential internal control problems for Blue Cross and could result in the development of improper rates.

Recommendation 7: *Blue Cross should develop a robust and readily understandable documentation system for its large group rate development process.*

7. Large Group Renewal Business Rates (Renewal Underwriting)

The Auditor requested a random sample of 30 renewal quotes with effective dates from 2007 through 2009 to evaluate the renewal business rating methodology. The requested quotes included those from various brokers, at least one from every Blue Cross underwriter, and a variety of group sizes. Blue Cross provided hard copies of each renewal group's underwriting support and documentation. In the course of its evaluation, the Auditor:

- Compared the factors used in the development of the rates by underwriters to those provided by the actuarial department to determine if the development of the rates utilized the correct factors;
- Compared the rating methodology to that filed with OHIC to verify that the renewal rate development was consistent with the current approved rating method;

- Analyzed documentation provided by underwriters to determine if adjustments to the rating formula, and other adjustments, followed published underwriting procedures;[21] and
- Inquired further about any issues or inconsistencies discovered.

While the Auditor found that the rating formula used was consistent with the filing submitted to OHIC, the Auditor also found that underwriters enjoyed broad discretion to deviate from the rating formula based on so-called "underwriting judgment" and the perceived need to offer rate concessions for competitive reasons. As a result, the Auditor found inconsistencies in rates offered to large groups. The most common inconsistencies observed were:

- Inconsistent adjustments applied to the experience of renewal groups;
- Inclusion of margins for pooling and claim reserves in renewal rate development, but not in new business rate development; and
- "New business credits" offered to new groups, but not renewal groups.

The Auditor also found that not all underwriter adjustments were supported by mathematical formulae. Many underwriter adjustments were applied to hit a price point, followed by *ex post* analysis of experience to justify why a change to the calculated premium should be made. As a result, the Auditor concluded that market concessions were likely documented as adjustments due to beneficial experience. In other words, underwriters were using experience adjustments to justify a pre-determined rate level.

[21] When analyzing documentation provided by underwriters to determine if adjustments followed published underwriting procedures, the Auditor noted that many underwriting procedures indicated the underwriter may vary from the guidance included in the underwriting procedures if, within their underwriting judgment, a deviation from the suggested procedure is warranted. Such underwriting judgment led to many inconsistencies in the application of adjustments to each group's rates. The Auditor noted that this is not inconsistent with the rating formula filed with OHIC because the formula does not reference any underwriting guidelines and the formula indicates that rates can be adjusted due to numerous factors. However, the use of such procedures contradicts explicit instruction given to Blue Cross by OHIC in 2007 as a part of the OHIC approval process for Blue Cross's large employer group renewal business manual. Directives provided by OHIC during the approval process, in addition to mandatory changes required by OHIC to language included in the filed manual, made clear to Blue Cross that rates could not be adjusted in a manner that is either unfairly discriminatory or inconsistent with the express language of the manual.

The Auditor also found that the Spend Down account (discussed earlier) was inconsistently applied across the groups. Underwriters had the option of removing or including the Spend Down load based on the experience of the group being rated. This had the effect of reducing the premium for some groups at the cost of increases to other groups.[22]

Blue Cross did employ a grading process to gauge the relative risk of a particular large employer group, but the actual application of the grading process by the underwriters appeared to render the process meaningless. The process utilized a grading system by which groups were reviewed and assigned a risk score and letter grade based on weighted criteria including enrollment participation, strategic importance, historical loss ratio, excess claim potential, age/gender adjustment factor, and predictive modeling results. Underwriting indicated that this grade was used as a measure of strategic importance and one of the risk assessment tools to determine an adequate rate level. However, the risk scores and grades appear to have had little impact on the concessions the underwriters were willing to offer any particular group. If the grading process worked as contemplated, one might expect the more valuable "A" or "B" rated groups to be more likely to receive rate concessions as opposed to the less valuable "C" or "D" groups. This, however, was not the case. Of the 30 quotes reviewed by the Auditor, groups rated "C" or "D" received similar reductions compared to groups rated "A" or "B." In addition, "F" groups received some of the highest reductions after the initial quote was determined. Furthermore, projected loss ratio for renewal groups were not monitored based on these pricing decisions.

Of the 30 quotes reviewed, approximately 80% included underwriter adjustments that were not applied in a consistent manner. Sixteen of the quotes received additional adjustments in response to competitive quotes and internal discussions with the sales department. These adjustments ranged from -9.5% to 2.4% depending on the group. In order to justify these rates, the underwriter would apply manual experience adjustments to the rating formula—without any

[22] The Spend Down medical budget was exceeded by $2.5 million in 2009, exceeded by $2.7 million 2008, and under budget by $4.5 million in 2007. This compares to a spend down budget of $4.2 million, $5.3 million, and $10.2 million for 2009, 2008, and 2007 respectively. The budget has been approximately 0.6% of non-self funded premium except in 2007 when it was approximately 1.2%. The total premium expected to have been collected from large groups has been between 0% and 1% (or $0 to $3 million per year) less than the required premium over the time period reviewed (noting that the required premium for 2009 was deficient due to under funding administrative operating expenses).

evidence that these adjustments actually reflected more favorable experience than the group was initially priced. In addition, underwriter adjustments included such things as removal of the spend down load, reverting to the original baseline rate adjustment factors, and applying a partial new business credit to second-year business. Other adjustments included changes related to favorable or unfavorable predictive modeling scores and removal of large excess claims for terminated individuals to bring in line with how excess claims levels have been tracking in prior years. Many renewal rates included multiple adjustments.

In addition, groups that had previously received a new business credit typically had their credit reduced upon renewal, typically over a four-year period. This procedure was not always followed, though, leading to inconsistent rates.

Recommendation 8: *In order to simplify and clarify the renewal rating process, Blue Cross should apply a single adjustment (or perhaps a minimal set of adjustments) to the rate formula instead of multiple adjustments to various factors to allow for easier documentation and auditing of underwriting files and preventing mischaracterizations of the adjustments. The range of the possible adjustment should be capped (for example, an adjustment of up to 5%), should be included in Blue Cross's rate formula, and should be approved by OHIC.*

The Auditor also found that underwriting documentation was not detailed enough for auditing purposes. Many files only included minimal comments regarding the adjustment but did not include additional and necessary documentation, such as development of or rationale for the adjustment factors utilized. Also, the Auditor was informed that management sign off was sometimes required when adjustments were made to a group's rate, but documentation did not always reflect management sign off as required.

Recommendation 9: *Large group renewal rate development, including all underwriting adjustments and the bases for such adjustments, must be fully, consistently, and correctly documented.*

Underwriters enjoyed wide discretion with respect to rate concessions for renewal groups. Rate concessions provided to renewal groups were inconsistently applied. Grading processes, designed to assess and minimize risk in renewal rates, were ignored. Rate concessions were documented inconsistently and incorrectly. As a result, large group renewal rates were not consistent, not impartial, not properly documented, and were unfairly discriminatory under Rhode Island General Laws § 27-29-4(7).

Recommendation 10: *Large group renewal rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.*

8. Large Group New Business Rates (New Business Underwriting)

The Auditor tested a random sample of 34 new business quotes, both sold and not sold, with effective dates from 2007 through 2009 to review the new business rating methodology. The 34 new business quotes were drawn using a sampling approach similar to that used for the renewal business review. Blue Cross provided hard copies of each new business group's underwriting support and documentation. In the course of their evaluation, the Auditor compared the factors used in the development of the rates to those provided by the actuarial department to confirm that the correct factors were used and also compared the rating methodology to the methodology that had been submitted to OHIC on February 5, 2010[23] to verify that the new business rate development was consistent with the methodology submitted.

The Auditor concluded that the rating formula used during 2007 to 2009 was consistent with the filing submitted to OHIC. However, the Auditor noted that underwriters were vested with broad discretion to deviate from the formula based on their judgment and the need for market concessions. This broad discretion resulted in rating inconsistencies. New business credits and individual consideration varied from quote to quote and underwriter to underwriter and generally appear to have been applied inconsistently. The most common inconsistencies observed were:

- New business credits were applied inconsistently;

[23] As noted above, no formula was approved or on file with OHIC during the period covered by this audit. The sampled quotes were compared to the rate formula submitted by Blue Cross on February 5, 2010.

- Credibility percentage formulae were applied inconsistently for groups with prior experience;
- Margins for pooling and claim reserves were included in renewal rates, but were not included in new business rates;
- New business groups received "new business credits" and renewal groups did not.

Of the 34 quotes reviewed, the Auditor found, among other things, approximately 82% of the quotes reviewed included underwriter adjustments that were not applied in a consistent manner, twenty-seven quotes deviated from the new business credit guidelines, and two contained new business credits issued in excess of the 10.5% new business credit limit outlined by the underwriting procedures. The Auditor also found deviations based on who the underwriter and broker were. For example, the average difference between actual and maximum formula-based new business credit allowance for the examined quotes ranged from -6.8% to -0.5% depending on the underwriter. Also, the average difference between actual and maximum formula-based new business credit allowance ranged from -9.5% to 0.0% depending on the broker.

The Auditor also found that not all underwriter adjustments were supported by mathematical formulae. Based on its conversations with underwriters, the Auditor determined that, similar to what was seen in large group renewal underwriting, many underwriter adjustments were applied to hit a predetermined price point, followed by *ex post* analysis of experience to justify why a change to the calculated premium should be made. As a result, the Auditor concluded that market concessions were likely documented incorrectly as experience adjustments.

One quote was rated without an out-of-area adjustment although 60% of the group's members resided outside of the state. The underwriter failed to apply the out-of-area adjustment on the ground that the quoted rate would have been 50% higher if the adjustment was applied. The underwriter did not apply the out-of-area adjustment solely for competitive reasons. It is important to note that, because the Auditor only reviewed a small sample of cases, the actual number of such adjustments is not known. If this is not an isolated case and such failures to apply appropriate rating adjustments are in fact more prevalent, the resulting inadequate collection of premium could be extremely detrimental to Blue Cross's financial condition.

Another of the quotes contained an error due to an incorrect entry in the rating model relating to the "Comp Alliance Credit" adjustment (during a time when such adjustments were still permitted) for a group with an effective date of 2/1/2008. The adjustment factor was incorrectly entered as 0.97 instead of 0.93 resulting in a miscalculation of approximately 0.4%.

New business groups utilized a lower community claim cost than renewal groups since new business community claim costs did not include a margin for the claims pooling charge or the claims reserve.

Groups purchasing multi-year guarantees were offered a rate cap for the second year, however, the proper underwriting procedure was not always followed when those caps were developed. Sometimes the rate cap offered was less than that outlined in the underwriting guidelines. Other times it was greater. While the underwriting guidelines authorized underwriter deviation from the guidelines if necessary, there was no clear documentation detailing how rate caps that deviated from the underwriting guidelines were developed.

Recommendation 11: *Groups purchasing multi-year guarantees and rate caps should be offered only as approved by OHIC.*

Finally, underwriting documentation was not detailed enough for auditing purposes. Many files reviewed only included minimal comments regarding adjustments but did not include additional and necessary documentation, such as development of or rationale for the adjustment factors utilized. Underwriting documentation did not always indicate if management sign off was obtained.

Based on these findings, the Auditor concluded that new business rates were not developed in an impartial manner. The wide discrepancies among Blue Cross's new business rates demonstrate that subscribers with those rates were subject to unfair discrimination under Rhode Island General Laws § 27-29-4(7).

In general, the problems associated with large group new business underwriting are similar to those found in large group renewal underwriting: underwriters enjoyed overly broad discretion with respect to rate concession, rate concessions were inconsistently applied, and rate concessions were documented inconsistently and incorrectly. As a result, large group renewal rates were not consistent, not impartial, not properly documented, and were unfairly discriminatory. The recommendations for large group new business underwriting are therefore similar to those for large group renewal underwriting.

Recommendation 12: *In order to simplify and clarify the new business rating process, Blue Cross should apply a single adjustment (or perhaps a minimal set of adjustments) to the rate formula instead of multiple adjustments to various factors to allow for easier documentation and auditing of underwriting files and preventing mischaracterizations of the adjustments. The range of the possible adjustment should be capped (for example, an adjustment of up to 5%), should be included in Blue Cross's rate formula, and should be approved by OHIC.*

Recommendation 13: *Large group new business rate development, including all underwriting adjustments and the basses for such adjustments, must be fully, consistently, and correctly documented.*

Recommendation 14: *Large group new business rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.*

9. Large Group Dental Actuarial Rate Setting

The Auditor reviewed rating models and documentation supporting the dental actuarial rating process. This process entails the derivation of community premium rates and various other rating factors. Projection (trend) factors, comprised of utilization trend, price trend, and mix trend, were calculated on a quarterly basis. Community claims costs were developed on an annual basis and served as the starting point for all small group rating and large group new business rates. Community rates were developed for each benefit group and for group size categories. Benefit

modification adjustment factors were developed to reflect expected benefit plan value differences associated with various plan designs.

Dental operating expense rates were developed on a quarterly basis based on gross operating expense figures. Total dental operating expenses were split between claims handling expenses and general overhead expenses. The general overhead expenses were scaled based on group size. Claims handling expenses varied only by benefit group offerings.

In general, Blue Cross developed its dental rates based on its filed dental rating formula (it had been filed with DBR prior to the creation of OHIC). The Auditor found that the dental actuarial rate setting process appeared to be developed using leading actuarial practice and that Blue Cross's rate development was generally consistent with rate filings submitted to OHIC, with one significant exception: retention costs (i.e., certain administrative expenses) were not fully funded by the dental premium but were instead cross-subsidized by medical premium. This was not disclosed to OHIC and is a violation of R.I. Gen. Laws §§ 27-19-6 and 27-20-6 and DBR Regulation 23 and OHIC Regulation 1. Recommendation 6 addresses this significant problem.

10. Large Group Dental Rates (Dental Underwriting)

The Auditor's sample consisted of 18 randomly chosen quotes with effective dates in 2007 (3 quotes), 2008 (5 quotes), and 2009 (10 quotes). The groups reviewed were chosen based on a stratified approach, similar to that outlined in the large group medical underwriting sections, to ensure good representation from various underwriters, brokers, and effective dates. Blue Cross provided hard copies of each renewal and new business group's underwriting support and documentation. The Auditor's review was similar to that for the large group medical underwriting.

As was the case with large group underwriting, the Auditor found that dental rates were not developed in an impartial manner. Rate adjustments were not fully documented, not determined by formula, and not applied consistently across groups where adjustments were based on underwriter discretion and/or market concessions during renewal and new business rate

development. The Auditor also found that dental underwriting guidelines were not sufficiently robust and that underwriting documentation lacked detail. This also results in rates that are unfairly discriminatory under Rhode Island General Laws § 27-29-4(7).

Underwriter adjustments varied among groups for numerous reasons. The following adjustments were not applied consistently among the groups reviewed:

- Six groups received rate cap offers that were adjusted downward from the underwriting guidelines;
- Three groups had their rates loaded (that is, increased) due to volatility of prior year loss ratios or due to high prior year loss ratios;
- One group had its calculated rate increase reduced to ensure a rate hold;
- Three groups received, or were offered, a reduction in their increase for agreeing to a two year rate cap;
- Two groups received a reduction in their proposed rate due to a competitive bid or to avoid a competitive bid;
- One group received a reduction in rate coming off a rate cap in order to ease them into an adequate rate;
- One group's completion factors were adjusted due to immature claims;
- Four groups had their potential rate decrease changed to a rate hold because Blue Cross's policy is to not offer rate decreases on the theory that decreases result in rate instability (although this policy is not uniformly applied, see below);
- One group, although calculated to receive a rate decrease was instead given a rate increase approximately equal to trend;
- One group received a rate decrease due to a favorable three-year loss ratio; and
- Various groups received different new business credit factors than outlined in the dental underwriting procedures.

The Auditor was shown what appeared to be competitor rate proposals that applied reductions to their formula rates similar to reductions applied by Blue Cross. This may be indicative of a market-wide problem with respect to rate development inconsistency and merits further inquiry by OHIC.

The Auditor observed in some 2007 and 2008 rates that dental new business groups received new business credits up to 22%. In 2007 Blue Cross was attempting to gain business and had an overall individual rate adjustment goal of -11.3%. The overall individual rate adjustment strategy was to apply a 12% new business credit on the first 2,000 contracts and a 10% new business credit on the next 1,000 contracts. In 2008, the individual consideration goal was reduced to -5%.

Based on these findings, the Auditor concluded that dental rates were not developed in an impartial manner. In general, the problems associated with dental underwriting are similar to those found in large group underwriting, although the problem seemed somewhat more acute in dental underwriting. As a result, dental rates were not consistent, not impartial, not properly documented and were unfairly discriminatory under Rhode Island General Laws § 27-29-4(7). The recommendations for dental underwriting are largely similar, but not identical, to those for large group underwriting.

Recommendation 15: *In order to simplify and clarify the dental rating process, Blue Cross should apply a single adjustment (or perhaps a minimal set of adjustments) to the rate formula instead of multiple adjustments to various factors to allow for easier documentation and auditing of underwriting files and preventing mischaracterizations of the adjustments. The range of the possible adjustment should be capped (for example, an adjustment of up to 5%), should be included in Blue Cross's rate formula, and should be approved by OHIC.*

Recommendation 16: *Dental rate development, including all underwriting adjustments and the bases for such adjustments, must be fully, consistently, and correctly documented.*

Recommendation 17: *Dental rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.*

Recommendation: 18: *More detailed underwriting guidelines should be developed for dental. This should include clear guidance regarding the application of credits and rate caps (if approved by OHIC).*

11. Small Group and RIBA Medical Actuarial Rate Setting

In a nutshell, the actuarial rate setting process for small employer groups (with 50 or fewer eligible employees) appears to follow leading actuarial practices. The actuarial rate setting process for RIBA also appears to follow leading actuarial practices, with the exception of the underfunding of operating expenses, the exclusion of RIBA large claims, and the failure to disclose certain rate factors in the annual filing, as explained further below.

In general, rates developed during the period 2007 to 2009 were consistent with the Act and OHIC Regulation 11. Blue Cross adjusted rates only for age, gender, and family composition[24] and rates were developed on a four-tiered structure. Rates were developed solely from the rate manual and differences in rates were based solely on plan design.

The small group actuarial rating process applied to new and renewal rating for all small employer groups. RIBA actuarial rating followed an identical process, although with exceptions.

The Auditor performed a review of rating models and documentation supporting the small group and RIBA actuarial rating processes. Claims experience by service category (Inpatient, Outpatient, Surgical Medical, Major Medical, Pharmacy) were pulled; aggregate completion ratios were applied to convert the claims from a paid basis to a fully-complete incurred basis; liability factors, which account for out-of-system payments (e.g. electronic medical record physician incentive payments) were applied; new benefit adjustment factors were applied to account for the impact of broad expected changes to health care consumption patterns (e.g. impact of drug patent expirations); and projection (or, trend) factors (utilization, price and mix) were applied.

The individual claim rates for a standard medical plan and a standard pharmacy plan were developed based on distribution of contracts by plan and tier. Benefit relativity factors and

[24] Rates did vary based on additional factors when health status was an allowed factor and when the use of a dental discount factor was approved.

subscription rate ratios were applied to the standard plan individual claim rate to derive tiered claim cost rates.

Tiered operating expense rates were added to the tiered claim rates to derive the total tiered community premium rates. Expenses were projected based on budgets provided by Blue Cross's finance department.

Prior to finalizing community rates, the tiered total premium rates were adjusted via a pool normalization process. The community rate development process included a calculation of required claims revenue. Since the distribution of contracts by product, tier, and age/gender categories changes over time, a normalization factor was applied to ensure that Blue Cross collects the appropriate amount of revenue on renewing groups. The pool normalization factor also accounts for groups for which rates were limited by the statutory 4:1 rate limits. Once the pool normalization factor was calculated, it was applied across all tiered community premium rates for all products.

For RIBA, large claims over $100,000.00 during the experience period were pulled to be reviewed to determine if they should have been excluded from the community rate development process. These claims were then analyzed on a case-by-case basis to evaluate the likelihood of the continued high costs for each case. This was done on RIBA only and not on the broader small employer market. Blue Cross explained that RIBA was treated differently as a result of being a smaller population that is subject to a greater level of volatility, market considerations (to meet the expectations of RIBA brokers), and to prevent wide rate swings from year-to-year. The methodology used for removal of RIBA large claims was inconsistent between 2007 and 2009 because it was left open to actuarial/underwriter judgment.

Recommendation 19: *If Blue Cross wishes to continue to remove large claims from the RIBA experience, Blue Cross should establish a documented and actuarially justified methodology for removing such claims, establish a documentation protocol for any deviations from this methodology, and seek approval of the methodology from OHIC.*

The Auditor did not review the calculation of health status adjustment factors for rating periods for which health status was an allowable rating characteristic (pre1/1/2009). A prior market conduct examination (report dated February 9, 2010[25], order dated March 17, 2010[26]) concluded that the development of the Blue Cross health status indicator was inappropriate.

The Auditor found that rates appear to have been calculated using leading actuarial practice with the exception of not fully funding operating expenses during the last three quarters of 2009 despite OHIC not approving requested rate increases.[27] This resulted in inadequate rates and worse financial performance than expected. Recommendation 1 addresses the issue of under funded operating expenses.

The rating formula utilized was consistent with the rate factor filing submitted to OHIC, and compliant with small group rating regulations (specifically OHIC Regulation 11), with the exception of projection factors not filed with OHIC that could impact rate changes and a claims reserve margin that was not disclosed to OHIC. The projection factors not filed with OHIC include contracting adjustments, liability factors for out-of-system payments, and new benefit factors (state mandated benefits, Rx patent expiration, etc.). These factors most likely have a negligible impact on the rate increase estimates filed with OHIC and do reflect the most up-to-date information available. A claims reserve margin of 0.5% was present in the development of the base rates for every year reviewed. The use of this margin was not disclosed to OHIC in violation of OHIC Regulation 11, Section 12. While it may be common industry practice to include such a margin, Blue Cross should have disclosed the use and level of this margin to OHIC. Blue Cross's failure to make such a disclosure appears to be part of a larger pattern of failing to fully disclose its rating formulae, factors, and practices.

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[25] Available at the OHIC website at: http://www.ohic.ri.gov/documents/Insurers/RegulatoryActions/2010_Health_Status_final_order_/2_BCBSRI Health Status Exam Report and Attachments.pdf.
[26] Available at the OHIC website at: http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_Health_Status_final_order_/1_FINAL%20ORDER.pdf.
[27] As note previously, operating expenses during the last three quarters of 2009 were not fully funded based on a management decision. This under funding resulted in a loss of approximately 1% of premium for groups affected.

Recommendation 20: *Blue Cross must fully disclose and explain in its annual rate factor filing all small group rating components, charges, margins, and loads that are intended or expected to produce more than a de minimus effect on small group rates. For those rating components, charges, and loads that are intended or expected to produce a de minimus effect on small group rates, Blue Cross must provide more than a summary explanation.*

The issue of a filing certification is addressed in Recommendation 5.

12. Small Group and RIBA Medical Renewal Business Rates (Renewal Business Underwriting)

The Auditor tested all renewal groups with effective dates from 2007 through 2009 by recalculating all age gender factors and renewal rates. Rates were developed consistent with OHIC Regulation 11 with the application of only the allowed rating factors with the exception of the health status factor, noted previously.

Minor issues resulted from outdated census data. For example, December 2009 renewal groups were developed based on age/gender factors derived from census information created using an earlier pull from the enrollment database due to timing and data availability. This resulted in 62 groups with underpriced contracts and 65 groups with overpriced contracts. The net impact was a loss of $433 for Blue Cross. Likewise, November 2008 renewal groups were developed based on age/gender factors derived from census information created using an earlier pull from the enrollment database due to timing and data availability. This resulted in 70 groups with underpriced contracts and 35 groups with overpriced contracts. The net impact was a loss of $3,475 for Blue Cross.

13. Small Group and RIBA Medical New Business Rates (New Business Underwriting)

The Auditor tested all new July 2009 groups; all new groups in November 2007, 2008, and 2009; and a sample of 20 unsold groups in each of 2007, 2008, and 2009 each. The Auditor found that rates were developed consistent with the Act and OHIC Regulation 11, applied only the allowed

rating factors, and were calculated consistent with the rate filings submitted to OHIC, with the exception of the health status factor previously discussed. Only minor errors were noted.

14. Small Group Dental Actuarial Rate Setting

The dental actuarial rate setting process appears to have been developed using leading actuarial practice. The Auditor reviewed rating models and documentation supporting the dental actuarial rating process. This involved the derivation of community premium rates and various other rating factors. Projection (trend) factors (utilization, price, and mix) were calculated on a quarterly basis. Community claim costs were developed on an annual basis. Community rates were developed for each benefit group for and group size category. Benefit modification adjustment factors were developed to reflect expected benefit plan value differences associated with various plan designs. Dental operating expenses were developed on a quarterly basis based on gross operating expense figures.

As noted earlier, dental operating expenses were not consistently fully funded by the dental premium over the time period in which we reviewed the rate development. This was addressed in Recommendation 6.

Community claims costs used to rate 2008Q4 and 2009Q1 renewals were too low due to a query error in pulling in enrollment data. The same issue affected 2008Q4 and January 2009 new business quotes.

With respect to the development of orthodontia rates, formula calculations were only applied in cases where the formula resulted in a rate increase. As a result, orthodontia rates were subject to judgment, applied inconsistently, and were unfairly discriminatory.

15. Small Group Dental Renewal Business Rates (Dental Renewal Business Underwriting)

The Auditor performed a review of the quarterly spreadsheets used to determine dental renewal rates on small groups.

Rates were not developed consistent with the rating method submitted to OHIC. The filed and approved methodology indicates the rates should have been based on the community rate adjusted for benefit relativity, group participation factor, industry adjustment factor, age/gender distribution (currently 1.0 for all groups), benefit maturity factor, projection factors, operating expenses, investment income, taxes, and reserve contribution.

Prior rates for all groups renewing during a particular quarter were compared to formula rates developed based on community rates, with adjustments for benefit groups covered and the load for increased anticipated utilization for groups that did not have prior dental coverage. The overall rate increase across all groups renewing in a particular quarter was evaluated and underwriter judgment was used to set a maximum and minimum rate increase percentage for the quarter. Groups subject to maximum or minimum rate increases had their rates varied by a randomly-generated percentage increase that varied within 0.25% of the maximum and minimum thresholds. The use of a varying, randomly generated percentage increase results in unfairly discriminatory rates.

The rating spreadsheet developed rates, but the increases were then limited to a maximum and minimum rate increase based on underwriting judgment. In the case where the maximum was set equal to the minimum all groups renewing had rates inconsistent with the filed methodology. Although the methodology filed did indicate that "All rating calculations that depart from this procedure will be documented and maintained for a period of three years . . . ," this did not give Blue Cross the right to deviate from the filed formula. Such an exception would render the filed formula meaningless. Furthermore, this very language was discussed with Blue Cross in 2007 when Blue Cross wanted to insert this language into its large group renewal manual. OHIC made clear at the time that Blue Cross could not use this language to develop unfairly discriminatory large group rates. Nevertheless, Blue Cross used this same language to justify the development of unfairly discriminatory rates in its dental business.

Rates were not developed using leading actuarial practice due to the maximum and minimum methodology and the use of a random number generator in determining how much over or under

the maximum/minimum a group's rate increase would be. Renewal rates were not determined in a manner consistent with the rate filing submitted to OHIC.

Recommendation 21: *Blue Cross should develop its dental renewal rates consistent with the rating method submitted to OHIC and in a manner that is not unfairly discriminatory, except that Blue Cross should phase in corrected rating on renewal business in order to limit the annual rate increase applied to groups who have not been rated adequately. The plan for this correction should be submitted to OHIC for approval.*

16. Small Group Dental New Business Rates (Dental New Business Underwriting)

In testing the new business rating methodology the Auditor requested a random sample of 42 new business quotes sold and 55 new business quotes not sold with effective dates from 2007 through 2009. Of those requested, Blue Cross provided 40 of the sold quotes and 41 of the unsold quotes. The quotes not provided were either not found or believed to have been destroyed. The Auditor was told unsold group documentation is only kept for approximately two years. Blue Cross provided hard copies of the rate sheets for each group being tested as well as a summary of the rates quoted. The Auditor's review involved comparing the factors used in the development of the rates to those provided by the actuarial department in order to determine if the development of the rates utilized the correct factors and comparing the rating methodology to that filed with OHIC to verify that the rate development was consistent with the current approved rating method.

Control activities associated with the dental underwriting process were extremely limited and resulted in rate calculation errors. Of the 81 quotes reviewed, approximately 30% were in error. The errors resulted from the miscalculation of community claim costs (resulting in a premium approximately 7% to 8% less than required for groups affected), use of inconsistent data sources (resulting in a premium approximately 0.25% less than required for groups affected), application of incorrect federal tax factors (resulting in a premium approximately 0.25% more than required for groups affected), use of incorrect projection factors, and errors that were not explainable due to lack of documentation regarding the development of the projection factors (resulting in rates

approximately 0.6% higher than required for one group and 2.5% lower for another group). In addition, one group that was analyzed included an orthodontics load of 30% to the orthodontics portion of the rate, however no formal underwriting procedure exists for the application of this load.

As previously discussed, operations expenses were not consistently fully funded by the dental premium over the review period, but were instead funded by medical premium.

The Auditor concluded that small group dental new business rates were not developed in an impartial manner. New business credits and other adjustments varied from company-to-company and appear to be applied inconsistently across groups. As a result, small group dental new business dental rates were not consistent, not impartial, not properly documented and were unfairly discriminatory as defined by R.I. Gen. Laws § 27-29-4(7).

Recommendation 22: *Small group dental new business renewal rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory. Blue Cross must ensure that its rate development process minimizes avoidable errors. To the extent needed, Blue Cross should also develop procedures for general pricing processes as well.*

17. Direct Pay Underwriting

The Auditor performed a detailed review of 139 Direct Pay applications from 2007, 2008, and 2009. This process involved underwriting each application based on the underwriting guidelines for that time period, identifying any questions or issues, and discussing those questions or issues with the Underwriters. The Auditor also reviewed AccessBlue applications related to the sample as well as unsuccessful applications that were not related to the sample but were randomly drawn. AccessBlue is a premium assistance program that pays a portion of a subscriber's monthly bill depending on income and type of plan.

When a Direct Pay application is submitted, an electronic file is created that documents the application from start to finish and includes the total underwriting debits assigned and the

underwriting decision. Applications that require medical underwriting are first sent to the junior underwriter to determine if the application can be denied based on underwriting criteria, specifically if any one of a list of conditions is present. If the junior underwriter finds a condition on the list, the application can be "auto-denied" and an "AD" is indicated as the reason for the denial. If the application is not auto-denied it is sent to an underwriter for further review.

The underwriter reviews the application based on the information noted by the applicant. Debits are assigned for each of the applicant's conditions and medications based on the underwriting guidelines for a given time period. If an application has debits for conditions and medications that meet a certain threshold, the application fails medical underwriting. Initially the debit cut off was set at a lower threshold, but the threshold was increased in order to increase the pass rate to a level consistent with prior criteria.

Applicants who fail underwriting but who had a previous policy and were HIPAA eligible are given a policy with the standard rate, or Basic pool. This pool is also referred to as Pool I. If the failing applicant did not have a previous policy or was not HIPAA eligible, the applicant was required to wait until open enrollment (currently May 15th to June 15th) to enroll in Pool I. Applicants who pass underwriting may enroll at any time of the year and are placed in the Preferred pool, or Pool II.

If an application does not list any known conditions, the following guidelines are used to underwrite the application:

- If the applicant has a previous Blue Cross membership record and does not have any claims in the Blue Cross database for the past 2 years, the application will pass medical underwriting.
- If the applicant is new, under 35 years of age, and does not have claims in the Blue Cross database, the application will pass medical underwriting.
- If the applicant is new, older than 35 years of age, and does not have claims in the Blue Cross database, the underwriter should request medical records from the applicant to verify that they do not have any existing conditions that were not noted on the application.

If an underwriter has a question regarding the information in the application or the claims in the Blue Cross database, they can request medical records from the applicant and their dependents, if applicable. Underwriters may request medical records if the time period around a condition is not indicated.

If an application is denied, the applicant has a chance to appeal the decision by submitting medical records. The underwriter reviews the additional medical records and will decide to either overturn or keep the original decision.

Direct Pay applicants can apply for the AccessBlue program if they believe they are eligible for premium assistance. AccessBlue has two levels of premium assistance based on gross annual household income and family size. Applicants who qualify for RiteCare are rejected when they apply for AccessBlue. They receive a rejection letter indicating that if their application for RiteCare is denied their AccessBlue application will be revisited.

If a member applies for AccessBlue and additional information is requested, the applicant has 60 days to provide the requested information. If the information is not received, the AccessBlue application is rejected and the applicant is informed that the reason for rejection is a failure to provide requested information.

With respect to the underwriting methodology used after April 1, 2008 to underwrite families, the Auditor found that the methodology is inconsistent with industry norms. From the inception of the program until April 1, 2008, Blue Cross used guidelines that were obtained from Blue Cross & Blue Shield of Georgia for Direct Pay and Non-Group Plan 65 underwriting. These guidelines used Accept/Reject assignment for each assumed diagnoses.

During that period, if an individual member of a family was rejected, then the family application was rejected. This is consistent with industry practice. On April 1, 2008 Blue Cross began using its current system, which uses debit points for diagnoses and medications for Direct Pay underwriting. Debit points from all members in a family application were added together and

compared to the debit point limit in the same fashion as an individual Direct Pay application, i.e., utilizing the same threshold number of points for a family direct pay plan and an individual direct pay plan. This methodology is inconsistent with industry practice. A methodology similar to the prior methodology should be used, in which each family member is evaluated separately.

For example, an individual receiving 25 debits due to various diagnoses would pass medical underwriting. However, a family of three people each receiving 15 debits would not pass since the sum of the three debits would be greater than 25 points.

In its sample, the Auditor found one family that would have been categorized as a Pool II family by Blue Cross but was relegated Pool I rates due to Blue Cross's use of this inconsistent methodology. When the Auditor reviewed this same family, it noted additional debit points not counted by the Blue Cross underwriter. Therefore, the Auditor would have categorized this as a Pool I family anyway. Since Blue Cross guidance is to stop counting debit points once a member/family fails, had Blue Cross researched this family further they may have concluded that this family should have been in Pool I even under the prior utilized methodology.

Recommendation 23: *Blue Cross should underwrite family members on an individual basis, consistent with the industry norm.*

Documentation is also a problem. Internal underwriting guidelines contain limited documentation, underwriters inconsistently documented the reason for the debits assigned, and other documentation issues were observed. For example, while the auto-deny list appears to be used in the manner it was intended, documentation problems created discrepancies. There were seven auto-denials in the applications tested, six were determined to be correct. One application incorrectly based its auto-denial on an alleged fact not contained in the record relating to a hip replacement. After finding the discrepancy regarding hip replacement on the auto-deny list, the Auditor randomly checked other conditions on the auto-deny list. Additional discrepancies were identified. The Auditor was not provided any documentation or reasons for these discrepancies.

Recommendation 24: *Blue Cross should develop a process for more robust and consistent documentation for Direct Pay underwriting.*

The Auditor also found that application of underwriting guidelines was inconsistent. For example, an incorrect assumption about the type of counseling received by an applicant led to the wrong pool assignment. In other cases, a condition identified by the applicant was overlooked or ignored. In other cases, the appropriate severity of the condition was not determined by the underwriter. In one case, the applicant's medical records noted sleeplessness, "evidence of psychiatric illness", and that the applicant was hearing voices. Moreover, the applicant was advised to get a mental evaluation and there was a diagnosis of depression. Nevertheless, the underwriter did not assign any debit points for these diagnoses and did not ask for additional information.

The general guidelines for requesting medical records for applications are incomplete and not always followed by underwriters. The Auditor identified 14 cases where the underwriter did not request medical records when such records should have been requested. Twelve of these cases passed medical underwriting. The Auditor concluded that with additional information these applications may not have passed medical underwriting. The other two cases failed medical underwriting. The Auditor concluded that with additional information these applications may have passed medical underwriting and received a lower premium rate.

The Auditor also found that underwriters assign debits inaccurately. For example, eight applications tested were not assigned the correct debits for height/weight mix. Not assigning height/weight debit points is not an issue for failed applications that are auto-denied or have several chronic diagnoses. However, not considering debit points for height/weight mix on applications could lead to an incorrect pool assignment.

Inconsistencies in criteria for requesting medical records were identified. Underwriters made assumptions based on the information provided when medical records should have been requested in 13 applications tested. Medical records should be requested on any cases in which a difference in diagnosis severity could result in a change in pool. Underwriters should clearly

document when assumptions were made when it is believed not to be necessary to request medical records.

Internal guidelines are not well documented or not documented at all.

Recommendation 25: *Blue Cross should develop underwriting documentation and guidance that is more thorough and provides clear guidance to underwriters.*

The Auditor also noted that Blue Cross had assigned family rates based on whichever spouse birthday fell earlier in the calendar year. Thus, if one spouse was born in January and the other spouse was born in October, the rate would be based on the age of the spouse born in January. This resulted in some members receiving rates based on an older spouse or a younger spouse. The result is inconsistent and potentially random rating for families if spouses are not the same age. For example, if a family in Pool II had been comprised of one spouse who was 36 and one spouse who was 29, the rates could differ significantly depending on the month of their births. Beginning in January of 2010, however, Blue Cross began to base the rate on the age of the applicant. Guidance was given to Blue Cross customer service to coach the member that the family rate would be based on the applicant no matter the age of the spouse. This allows the member to choose if they want the rate to be based on the older or younger spouse. This is also an unsatisfactory method. Not only could this lead to inadequate rates, it still allows for the possibility that the rate will vary not based on risk, but based on the age of the person filling out the application form. If an older spouse fills out an application without understanding the consequences, that family will pay a higher rate than a similarly situated family that submits an application by the younger spouse. As a result, some family rates were probably not consistent, not impartial, and were probably unfairly discriminatory in violation of R.I. Gen. Laws § 27-29-4(7).

Recommendation 26: *Direct Pay family rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.*

18. Non-Group Plan 65 Underwriting

The Auditor reviewed 15 Non-Group Plan 65 applications from 2007, 2008 and 2009 (5 from each year). The review process was similar to that used for Direct Pay applications.

When an application is submitted an electronic file is created. The electronic file documents the application from start to finish indicating when the application was submitted, standard details from the application, and the underwriting decision.

The application is reviewed by the underwriter based on the information provided by the applicant and the Blue Cross & Blue Shield of Georgia guidelines used for Direct Pay. These guidelines list a variety of conditions and indicate whether an application should be accepted or rejected if they have a specific condition. If an applicant has one or more conditions that are rejected based on the guidelines, the application is rejected. In other words, the conditions in these guidelines are either rejected or accepted. There is no point system used to debit these applications.

After the underwriter has reviewed the information provided by the applicant, the underwriter reviews the Blue Cross claims database for claims made by the applicant in the past 2 years. If a claim in the Blue Cross database is associated with a condition that should result in a rejection, the application is rejected for the condition and for a discrepancy with the claim history.

If an application is submitted that does not list any known conditions the following guidelines are used to underwrite the application.

- If the applicant has a previous Blue Cross membership record and does not have any claims in the Blue Cross database for the past 2 years, the application will pass medical underwriting; and
- If the applicant is new, the underwriter should request medical records for the applicant to verify that they do not have any existing conditions that were not noted on the application.

If an underwriter has a question regarding the information in the application or the claims in the Blue Cross database they can request medical records from the applicant. Underwriters may choose not to request medical records if the member would fail due to other conditions unrelated to the diagnosis that contains incomplete information.

If an application is denied, the applicant has a chance to appeal the decision by submitting medical records. An underwriter reviews the additional medical records and will decide to either overturn or keep the original decision. The Medical Director is charged with the final decision regarding the outcome of an appeal.

In reviewing the files, the Auditor found that the condition resulting in denial is not always documented and the explanation for the rejection is rarely documented.

Recommendation 27: *The decision to accept or reject a non-group Plan 65 application should be adequately documented, including the condition(s) resulting in rejection of the application and the reasons for rejecting an application.*

The guidelines used to review the Non-Group Plan 65 applications are incomplete and require the underwriter to make many assumptions.

Recommendation 28: *Blue Cross should develop new and/or more detailed guidelines for applicants for non-group Plan 65.*

19. Group Plan 65 Actuarial Rate Setting

The Auditor performed a detailed review of the 2007, 2008, and 2009 rate development for group Plan 65, which included trend development, community rate development, and the experience rates developed for the two experience rated groups for the three years encompassed by the review.

Trend development files were reviewed in detail, noting the data source of the experience, the assumptions involved in developing the trend, and verified that the resulting trends of the analysis were consistent with those filed with the OHIC. The Auditor verified that the rating factors approved by the OHIC were utilized to develop the quarterly community rates and the experience rates for the two experience rated groups. The Auditor reviewed the community rate development files for any calculation errors and to verify that the trend factors, reserve factors, and tax factors were consistent with the factors filed and approved for the 12 quarters that were tested.

The group Plan 65 community rates were developed by analyzing the community claim costs over a twelve month incurred period. These community rates were projected to the applicable time period utilizing completion factors and cost and utilization factors broken out by different Medicare cost categories, such as Medicare Part A deductible, Medicare Part A copay, Medicare Part B deductible, Medicare Part B copay, and so on. Additional factors, such as operational expenses and reserve contribution, were applied to the trended claim costs in order to develop the required premium levels. Experience rated groups used a similar methodology in the development of their rates except the group's experience was utilized to develop the premium level.

The Auditor concluded that base group Plan 65 rates were developed consistent with the rate filing approved by the OHIC.[28] However, the Major Medical and Pharmacy rate development differed from the methodology used to develop Group Commercial medical and pharmacy rates. The Auditor was informed that the current Group Commercial rate filing is applicable to these products, but it observed that the methodology is slightly different than that filed, and the previous filing does not mention group Plan 65 riders in the description of the rate filing. Therefore, the Auditor concluded the rate development for these riders has never been submitted to OHIC for approval. Again, this appears to be part of a pattern for Blue Cross.

[28] Except for groups that had delays in implementation of their rate increase (per the formulas on page 5-9 of the rate filing dated December 23, 2005) and groups who had renewal guarantee periods other than 12 months (page 2 Section A, item 5).

Also, the methodology utilized to develop the skilled nursing facility rider is not on file with OHIC. In addition, the methodology was changed in the 3rd quarter of 2008, but OHIC was not informed of this methodology. The change in methodology did not result in a material change in the rates being charged to any current or future groups.

Recommendation 29: *Blue Cross must ensure that it develops its group Plan 65 rates based on a filed and approved rate formula.*

The rating factors used in the development of the rates are consistent with those filed with the OHIC with the exception of one advanced quoted experience rated group. Rates for one of the two experience rated groups analyzed were developed using a 2.33% reserve factor and a 2.25% tax factor. These are equivalent to what was filed at the time the group was rated, but the factors that were ultimately approved were a 1.33% reserve factor and a 2.00% tax factor. The Auditor indicated a belief that this was not a significant issue as Blue Cross used the best available information at the time the group was rated. However, an underwriting guideline should be developed regarding the development of rates in such cases.

20. Group Plan 65 Rates (Group Plan 65 Underwriting)

The Auditor tested the accuracy of each group being rated—a 100% sample. The review involved determining which level of benefits a member requested based on the contract number provided, independently determining the correct rate that should have been charged to the group based on the cycle date, effective date, and the benefits provided, and comparing the rate the Auditor determined to be correct to the rate Blue Cross actually charged to the group. When the Auditor encountered a group whose rate was not consistent with the expected rate based on the factors filed with OHIC the Auditor asked actuarial or underwriting to verify the rates and benefits and contract number. If it was confirmed that the rate and contract number were correct, the Auditor asked underwriting to provide additional information regarding the development of the rates to determine if the error occurred in underwriting or after underwriting had developed the rates. For large groups, the Auditor was provided underwriting support for the rates assigned to each group. For small groups the Auditor was informed whether or not there was an error.

Finally, the Auditor documented the reason for the error, or why there was not an error, and verified its understanding with Blue Cross.

Except for experience rated groups, the small and large groups were charged the premium rates developed by the actuarial rating methodology, with the exception of groups that have a delay in their rate increase or who request a guaranteed rate period in excess of 12 months. Underwriting works with Actuarial to develop the rates. Underwriting may adjust the rates dependent on competitive pressures or the level of rate increase. Competitive pressures may result in a discount applied to the rate, and if the actuarial formula results in minimal changes, the group may be offered a rate hold. Guidelines to either of these adjustments are not documented.

As a result, experience rated groups were not always charged a rate consistent with that calculated by the rating formula. One group was given a rate hold in 2008 due to competitive pressures and a rate hold in 2009 due to an ongoing arbitration hearing. Another group was given a rate hold instead of a rate decrease of 0.25% in order to limit disruption within the group. In total, 41 errors were identified regarding groups being charged incorrect rates related to the benefits that were administered. The errors included:

- One error was due to the underwriter charging a group the 1st quarter 2007 rate instead of the 2nd quarter 2007 rate;
- One error was due to underwriting's failure to revisit a case of a one month rate hold, which resulted in a twelve month rate hold instead of a one month rate hold;
- Four errors were due to groups being rated inconsistent with the rate filing approved by OHIC; and
- Two vision benefit rates were quoted as $100 hardware benefits, but the group was provided the $50 hardware benefit. This was due to the "non-standard" $50 rates not being available. Even though these were not available underwriting failed to request a rate quote from Actuarial for this "non-standard" benefit. This resulted in groups being charged approximately $1.00 PMPM more than they should have been charged.

Other errors resulted from input of an incorrect benefit code into the claims system, resulting in groups receiving benefits that they did not pay for, or resulted in groups receiving less benefits than they were charged for; communication of an incorrect premium by the sales force; and rates incorrectly loaded.

Finally, groups that requested a guaranteed rate for more than 12 months did not always have their rate developed consistently, and in one case the rate was developed inconsistent with the methodology filed with OHIC.

Group Plan 65 rates were not impartial, were not consistent, and were unfairly discriminatory in violation of R.I. Gen. Laws § 27-29-4(7).

Recommendation 30: *Group Plan 65 rates must be developed in an impartial and consistent manner, should not be unfairly discriminatory, and must follow filed and approved rating formula.*

There is not any requirement that the underwriter develop clear documentation on how the ultimate rate was determined.

Recommendation 31: *Group Plan 65 rate development, including all underwriting adjustments and the bases for such adjustments, must be fully, consistently, and correctly documented.*

Many of the foregoing findings revealed overcharges or potential overcharges to Blue Cross customers and potentially higher charges due to unfairly discriminatory rates.

Recommendation 32: *Based on the findings in this report, to the extent that Blue Cross overcharges have been identified, Blue Cross should provide refunds to overcharged customers. To the extent that some Blue Cross customers were overcharged due to unfairly discriminatory rates, refunds should also be provided. Such refunds should be based on the period covered by this report and thereafter.*

21. Conclusion

As a result of various prior problems noted by OHIC with respect to Blue Cross's rating and underwriting practices over the past few years, OHIC scheduled this targeted market conduct examination of Blue Cross's current rating and underwriting practices, the findings of which are contained in this report. The examination revealed a number of problems related to Blue Cross's rating and underwriting practices, the breadth and consistency of which suggest weak management controls and a corporate culture that favors aggressive marketing efforts at the expense of consistent and appropriate application of underwriting and rating rules and procedures. Such practices are potentially risky and could present a serious financial risk to the organization. As such, it is the opinion of the examiners that the problems uncovered during this examination must be addressed by the corporation at the highest level.

22. Acknowledgement Cooperation, Acknowledgment of Limitations, and Certification of Complete Disclosure of Material Findings

The courteous cooperation and assistance extended to the examiners and the Auditor by the officers and employees of Blue Cross during the course of the examination is gratefully acknowledged. Acknowledgement is also made of the assistance rendered by the Auditor, Deloitte Consulting LLP.

While the samples drawn by the Auditor and used by the examiners for this report do not give complete assurance that all errors, irregularities, improper activities, and statutory/regulatory violations have been detected, those that were detected during the course of this examination have been disclosed. The examiners were not informed of, and did not become aware of any

other errors, irregularities, improper activities, statutory/regulatory violations that could have a material effect on the market conduct condition of Blue Cross.

Respectfully Submitted,

Joseph Torti, III
Deputy Director and Superintendent of Insurance
Rhode Island Department of Business Regulation

John Aloysius Cogan Jr.

Blue Cross & Blue Shield of Rhode Island
Market Conduct Examination

APPENDIX A:
Summary of Recommendations

Recommendation 1: Operating expenses should be fully funded. If competitive adjustments are to be made, such adjustments should be made as part of a single, consolidated adjustment, subject to the limitations discussed in this report.

Recommendation 2: Blue Cross must ensure that it develops its new and renewal rates based on a filed and approved rate formula.

Recommendation 3: Blue Cross must ensure that it complies with all filing and approval requirements before it offers rates.

Recommendation 4: Blue Cross must fully disclose and explain in its filed and approved formula and its annual rate factor filing all large group rating components, charges, and loads that are intended or expected to produce more that a *de minimus* effect on large group rates. For those rating components, charges, and loads that are intended or expected to produce a *de minimus* effect on large group rates, Blue Cross must provide more than a summary explanation.

Recommendation 5: The Chief Executive Officer and Chief Financial Officer of Blue Cross must personally certify in any required rate-related filing that Blue Cross has fully disclosed all rating components, charges, loads, and factors that are intended or expected to produce more that a *de minimus* effect on rates. The CEO and CFO must also certify that the filing (1) is true and complete, (2) contains neither untrue statements of material fact or nor omissions of material fact, and (3) is not misleading.

Recommendation 6: Blue Cross should not cross-subsidize its dental business operating expenses with its medical business operating expenses unless such cross-subsidization is actuarially justified and fully disclosed to OHIC.

Recommendation 7: Blue Cross should develop a robust and readily understandable documentation system for its large group rate development process.

Recommendation 8: In order to simplify and clarify the renewal rating process, Blue Cross should apply a single adjustment (or perhaps a minimal set of adjustments) to the rate formula instead of multiple adjustments to various factors to allow for easier documentation and auditing of underwriting files and preventing mischaracterizations of the adjustments. The range of the possible adjustment should be capped (for example, an adjustment of up to 5%), should be included in Blue Cross's rate formula, and should be approved by OHIC.

Recommendation 9: Large group renewal rate development, including all underwriting adjustments and the bases for such adjustments, must be fully, consistently, and correctly documented.

Recommendation 10: Large group renewal rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.

Recommendation 11: Groups purchasing multi-year guarantees and rate caps should be offered only as approved by OHIC.

Recommendation 12: In order to simplify and clarify the new business rating process, Blue Cross should apply a single adjustment (or perhaps a minimal set of adjustments) to the rate formula instead of multiple adjustments to various factors to allow for easier documentation and auditing of underwriting files and preventing mischaracterizations of the adjustments. The range of the possible adjustment should be capped (for example, an adjustment of up to 5%), should be included in Blue Cross's rate formula, and should be approved by OHIC.

Recommendation 13: Large group new business rate development, including all underwriting adjustments and the basses for such adjustments, must be fully, consistently, and correctly documented.

Recommendation 14: Large group new business rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.

Recommendation 15: In order to simplify and clarify the dental rating process, Blue Cross should apply a single adjustment (or perhaps a minimal set of adjustments) to the rate formula instead of multiple adjustments to various factors to allow for easier documentation and auditing of underwriting files and preventing mischaracterizations of the adjustments. The range of the possible adjustment should be capped (for example, an adjustment of up to 5%), should be included in Blue Cross's rate formula, and should be approved by OHIC.

Recommendation 16: Dental rate development, including all underwriting adjustments and the basses for such adjustments, must be fully, consistently, and correctly documented.

Recommendation 17: Dental rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.

Recommendation: 18: More detailed underwriting guidelines should be developed for dental rates. This should include clear guidance regarding the application of credits and rate caps (if approved by OHIC).

Recommendation 19: If Blue Cross wishes to continue to remove large claims from the RIBA experience, Blue Cross should establish a documented and actuarially justified methodology for removing such claims, establish a documentation protocol for any deviations from this methodology, and seek approval of the methodology from OHIC.

Recommendation 20: Blue Cross must fully disclose and explain in its annual rate factor filing all small group rating components, charges, margins, and loads that are intended or expected to produce more than a *de minimus* effect on small group rates. For those rating components, charges, and loads that are intended or expected to produce a *de minimus* effect on small group rates, Blue Cross must provide more than a summary explanation.

Recommendation 21: Blue Cross should develop its dental renewal rates consistent with the rating method submitted to OHIC and in manner that is not unfairly discriminatory, except that

Blue Cross should phase in corrected rating on renewal business in order to limit the annual rate increase applied to groups who have not been rated adequately. The plan for this correction should be submitted to OHIC for approval.

Recommendation 22: Small group dental new business renewal rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory. Blue Cross must ensure that its rate development process minimizes avoidable errors. To the extent needed, Blue Cross should also develop procedures for general pricing processes as well.

Recommendation 23: Blue Cross should underwrite family members on an individual basis, consistent with the industry norm.

Recommendation 24: Blue Cross should develop a process for more robust and consistent documentation for Direct Pay underwriting.

Recommendation 25: Blue Cross should develop underwriting documentation and guidance that is more thorough and provides clear guidance to underwriters.

Recommendation 26: : Direct Pay family rates must be developed in an impartial and consistent manner and should not be unfairly discriminatory.

Recommendation 27: The decision to accept or reject a non-group Plan 65 application should be adequately documented, including the condition(s) resulting in rejection of the application and the reasons for rejecting an application.

Recommendation 28: Blue Cross should develop new and/or more detailed guidelines for applicants for non-group Plan 65.

Recommendation 29: Blue Cross must ensure that it develops its group Plan 65 rates based on a filed and approved rate formula.

Recommendation 30: Group Plan 65 rate must be developed in an impartial and consistent manner, should not be unfairly discriminatory, and must follow filed and approved rating formula.

Recommendation 31: Group Plan 65 rate development, including all underwriting adjustments and the basses for such adjustments, must be fully, consistently, and correctly documented.

Recommendation 32: Based on the findings in this report, to the extent that Blue Cross overcharges have been identified, Blue Cross should provide refunds to overcharged customers. To the extent that some Blue Cross customers were overcharged due to unfairly discriminatory rates, refunds should also be provided. Such refunds should be based on the period covered by this report and thereafter.

Blue Cross & Blue Shield of Rhode Island
Market Conduct Examination

APPENDIX B:
Response of Blue Cross